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		State of Maryland		artment of I <i>rtificate of</i>			0007	37001
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Physici /Medic		Deborah A. Freyman				Month	Law 18 Year	07 2:00 AM
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Funeral		Baltimore Washington Medical 5. Social Security Number 6. Sex 7. Age (In yrs. In	last birthday)	If Under 1 Year		8. Date of Birth	Anne A	rundel inthplace (State or Foreign
Director		216-60-7421 1□M 2⊠F 56	Yrs.	Months Days	Hours Min.	Oct. 5,	, Year) C	cyland
and		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Lo	ocation				10d. Inside City Limits
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th the or 28a e noti	Director	10e. Street and Number	2020 0	10f. Zip Code		1	0g. Citizen of What C	country?
ath wi		3560 Horton Ave.		21226			United Sta	
ter de items	Funeral	11. Maritat Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Ves 2 ☑ No	S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
ours af	by	3 ⊠Widowed 4 □ Divorced Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: W	hite
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Homem		ed) -	1	Own Home	
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Menta Menta arked atlc ev	To E	Perry Cantrell			Juanita	Adkins		
12 sho		19a. Informant's Name/Relationship (Type. Print)					r, City or Town, State,	
Healt Healt tem 2	8	Karey A. Foster/Daughter 20a. Method of Disposition 20b. Pl		ELIZADE1 sition (Name of matory or other pla			Maryland 20c. Location - City of	
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mit.	H	21. Signature of Funeral Strvice Licer Site						
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		23a. PaiNJ Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Do not ent			, ,		Approximate Interval Between Onset and Death
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Examiner			101100 0171					
B: / 15	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	refice of).					
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es tha igned I	by P	Part II. Other significant conditions contributing to death but not result	Iting in the ur	nderlying cause giv	ven in Part I.	23e. Did tot	pacco use contribute	to the cause of death?
requil	sted					1 🗆 Ye	es 2∐No 3∏F	Probably 4 🖂 Onknown
he law has t	Completed					24a. Was a autops perforr	y prior to	autopsy findings available completion of cause of
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Ing PI	ü	27. Manuar of Death 1 ☐ Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	Wor	ry at rk?		ow injury occurred	
Attend death ctor: y y the f	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At hor	me farm stre		Yes 2 □ No	28f Location (St	reet and Number or F	Rural Boute Number
al or / s after al Dire	Certification:	4 Homicide determined building, etc. (Specify)		sol, idetory, emec		City or Town		idiai i loute i vamber,
	edical (29a. Certifier (Check only (C	vledge, death	occurred at the ti	me, date and place,	and due to the cired at the time. d	ause(s) and manner a	as stated.
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F > F 8		Dange E. Wills	IMI	D41	365	N	lovember	18 2007
5	-	30 Name and address of person who completed cause of deathwitem	23a) (Type, I	Print)	O During	(2)	Rigerio F	1D 211/4
		29b. Signature and title of certifier 20 Name and address of person who completed cause of death (Item) 30 Name and address of person who completed cause of death (Item) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	301 6	XOSPITE	X PVIVE	, Olem	DUIT OF	-, ~~~
Stat Registra	~	31. Date filed (Month, Day, Year) 32. Registrar's Signature 100 / 2007	GOGA					

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permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If Item 27 Is marked other I any injury or other traumatic event, It

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certificate

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Yolanda

Yolanda

Chie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chik

MD

600 N. Wolfe ST

32. Registrar's Signature

Maryland 21215-0036

Baltimore,

DHMH 17 Rev 1/2001

State Registrar

29c. License number

RES -000

MD

Baltimore

29d. Date signed (Month, Day, Year)

13

2007

November

21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Jose Villela Ferreira 18,2007 0219 A November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 3,1928 9. Birthplace (State or Foreign Country) Brazil 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 ★M 2 □ F 79 616-40-0228 March Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7922 Roldrew Ave. 21204 Brazil permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Examiner must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking Banker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Villela မ Rodrigo Ferreira 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7922 Roldrew Ave. Towson, Maryland 21204 Lourdes White Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Dulanev Valley Memorial Cdn. 11-21-07 4 Donation 5 Dother (Specify) Timonium, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 21212 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner rayc if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Yeuneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burtal-transit completely filled in by the funeral director, page 2 should be detached for use as the burtal-transit ovonary that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4⊡Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autonsy Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 PNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certified 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 /

GAN-CARPEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 20b, perFH, C873, 11/20/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 17 FRED RONAL D FISHMAN 2007 11:53 P^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2139 WILKER AVENUE PARKVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 06/28/1944 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months 1 M 2 □ F 219-42-7563 63 NY Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes 2 No MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2139 WILKER AVENUE 21234 U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Ves 2 No If Nes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No WHITE Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWNER DRY CLEANING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ABRAHAM FISHMAN FRIEDA KURSHNER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2139 WILKER AVENUE - PARKVILLE, MD. 21234 JOANNE FISHMAN / WIFE 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State CARROLL CREMATION 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State HAMPSTEAD, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE. MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) arcindus Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Due to (or as a consequence of) If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 nknown

Physician /Medical Examiner

certificate be executed

Box 68760.

P.O. I

Division or Vital Records.

Physician:

or Attending

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within 24 hours after death To the Funeral Director;

Physician

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Examiner

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28a-f show at

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a, Was an autopsy performe 1□ Yes 2□

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 25 Nio

27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 4 ☐ Homicide

5 Pending investigation 6 Could not be determined

1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of (Month, Day Year)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause

MARUN TIFIELDMAN 31. Date filed (Month, Day, Year)

NOV 2 0 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** OTTIE 2007 1:58 GLOWACK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA MEDICAL ENTE BALTIUNRE UNIVERSITY OF MARYLAND If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday Funeral 122-18-7387 1 ☐ M 2 🔀 F 82 Director 10/05/1925 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or thems 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Prince George's Maryland Bowie 1√TYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3909 New Haven Court, Apt. C6 20716 U.S.A. Funeral . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No White þ Specify: 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodor Ruszczyk Mary Chuda 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia M. Glowacki/Daughter 3793 Eightpenny Lane, Bowie, Maryland 20716 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Stanislaus Roman 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. 4 Donation 5 Dother (Specify) 11/30/2007 Buffalo, New York Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 16000 Annapolis Road, Bowie, MD Robert E. Evans Funeral Home 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CORONARY ARTERY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine burial-tran Due to (or as a consequence of): physician a attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an . Were autopsy findings available prior to completion of cause of certificate has autopsy performed? Yes 2 X No death? 1 □Yes 2 □ No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Wo ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 🗽 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 140 1114120730 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SaiTH OKOYE MBRCY BATIMORE GEENE MO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 0 Registra

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Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit order for the funeral director. To Bo Completed by the Director and a second for the page 2 should be detached for use as the burial - transit order of the page 2 should be detached for use as the burial - transit order.	nainimen 2	IF FEMALE: 3b. Was decedent past 12 month	t pregnant in	2	3c. If yes, outco	Oa, b, prome of preging time of de	nancy 2	Fetal death	h 3		pregnancy	,	23	3d. Date of delive Month	ery Day Year
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Vital Rec ysician: The l his certificate l director, page	3	25. Was case refe examiner?	rred to medic	cal Hosp	ital:					e of Death (-	y one)			-
Ing Physic	₽┞	1 Yes 27. Manner of Dea	2 No	Позр	28a. Date of In	ient 2 🗸	ER/Outpa 28b. Time		DOA 28c. Inji	ury at Work		d. Describe	how in	dence 6 Oth	
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Division o within 24 hours after death of the Funeral Director: After completely filled in by the fune		3 Suicide 4 Homicide		uld not be termined	28e. Place of (Specify) M				гу, опісе	building, et		or Town, S	State)	Dr., Forestville	Rural Route Number, City e, MD
To the Hos within 24 h To the Fun completely	<u></u>	29a. Certifier (Check only one) 2		aminer:On	the basis of ex	amination a								and manner as st lace, and due to	
To with To com	Me	29b. Signature and	d title of certi		d manner stated	1.		2		se number				. Date signed (A	
	-	30. Name and add	a Sia	on who com	ME pleted cause of	death (Item	1 23a)		O.C	.M.E.			No	vember 17,	2007
10		Melissa Bra	assell, ME) Assis	stant Medica	al Examir	ner 11	1 Penn S	•	Baltimore	e, MD 21	1201			
Stat Registra		31. Date filed (Moi	0.00.00	0 2007		rar's Signati	re	seek							

DHMH 17 Rev 1/2001 OCME 2006

DCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** November Marv C. Gallagher 16, 2007 7:15AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Paradise Assisted Living Catonsville Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔽 F Months Days Hours Yrs Aug. 9, 88 Director 1919 PA 168-12-5254 Usual Residence of Decedent 10c. City, Town or Location la or 28a-f show t be notified at 10a. State 10b. County 10d, Inside City Limits Y Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Light Street, Apt. 409 21230 other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify ģ 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If flem 27 is marked other than any injury or other traumatic event. the Means injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Clerk Hecht Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Danie1 Dorrian ပ Cassie Burns 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Gallagher 26 Cotswold Court, Owings Mills, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/19/07 Carroll Cremation Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road SCO Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimers Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter thirdellying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ osteodoroses 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) AS3 (STC) 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification:

Examiner burial-transi attending physician Records, P.O. Box 68760 The law requires that the death certificate be the as signed by the a has e 2 certificate Division or Vital To the Hospital or Attending Physician: within 24 hours after death. this funeral After Director: To the Funeral

the

Baltimore, Maryland 21215-0036

23a

or items

'natural".

filed within 7 Hygiene.

28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

1 Pre-certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST PAul Total U 20212

19.07

State Registrar

Medical

+VANCES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physici	an	1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. N 2. Date of Death Month	lo. 3. Time of Death
/Medic Examir	cal	Sister Mary Helen 4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death	November	10, 2007 9:58 PM N
Funeral Director		311 24 3223		Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Jan 23, 19	9. Birthplace (State or Foreign Country) 923 Canada
aryfand show	7.	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
or 28e-f	Directo	MD 10e. Street and Number		10f. Zip Code	10g. 0	1 ☐ Yes 2 ☐ No X
<u> </u>	by Funeral Director	3725 Ellerslie A	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No	Use 21218 Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Pueric	Decity Yes or No- Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: White
within 72 iane.	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) 16a. Dece (Give College (1-4or 5+)	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king	Kind of Business/Industry
be file tal Hy d oth	To Be C	17. Father's Name (First, Middle, Last) Alexander Jamies 19a. Informant's Name/Relationship (T)	son Gray	18. Mother's Nam	ne (First, Middle, Maide Catherine O	Brien
of Heel		Rita J. Gray/niece 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	216 B	S. Southwood Ave	nue Annapo	
permit. Page Department of important: if any injury or once.		21. Signatur of Eureral Service Licens		Name and Address of Facility tate Anatomy Board altimore, MD 2120		altimore Street
Physician /Medical Examiner		23a Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not enti- ne cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onant and Death
rificate be executed g physicien end es the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
The law requires thet the death certific sie hes been signed by the ettending p bage 2 should be detached for use es i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
w requires ther been signed b should be det	ed by P	Part II. Other significant conditions con	ntributing to death but not resulting in the ur	nderlying cause given in Part I.		ouse contribute to the cause of death?
sician: The law requires the second result in section is second to be second to second the second second to second the second se	Completed by				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} 2 \) No	fospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Others	th Check only one	6 □Other (Specify)
Afte tune	Certification;	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Place of Injury - At home, farm, stribuilding, etc. (Specify)	Work? M 1 □ Yes 2 □ No	28d. Describe how inj 28f. Location (Street a City or Town, Sta	and Number or Rural Route Number
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medicai C	29a. Certifier (Check only one)	sician: To the best of my knowledge, death ner: On the basis of examination and/or inv and manner stated.	coursed at the time, date and place, vestigation, in my opinion, death occur	and due to the cause(red at the time, date a	s) and manner as stated nd place, and due to the cause(s)
	-	001 0:		29c. License number	29d D	late size of (March Con Vers)
To the withing To the company of the	2	29b. Signature and title of certifier Maryuus	Te J. Munden empleted cause of death (Item 23a) (Type,	NO DOOD 809	3	ate signed (Month, Day, Year)

07-08880 Kevin Gaffnev

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007

vin Gaffney		Please Ty	State of Maryl	and / Depa	rtment of	Health	and	Menta	Hyg	jiene	3	21	107	370	109
VIII Calling		- For State	tate of that y	Cer	tificate of	Death					eg. No.	£ C			
Physicia	_	Registrar 1. Decedent's Name (First, Mic	idle,Last)						2.	Date of Dea Month Novembe	ith Day	Year		me of Death 710 hrs	
edical Examir	ner	Kevin		Gaffney		4b. City, Tow		tion of [Novembe		007 County of I		101113	
		4a. Facility Name (if not institu 5 Beach Road	tion, give street and n	umber)	ľ	Glen Bu		cation of t	Deali			ne Arur			1
		5. Social Security Number	6. Sex	7. Age (in yrs. ta	st birthday)	If Under		If Under 2	24Hrs.	8. Date of B	rth (MM/D	D/YYYY)	9. Birthplac	e (State or	-
Funeral Director			1X M 2 F	4		Months	Days	Hours	Min.	Jan. (5. 19		Foreign Country)	MD	
	- }	215-84-7367 Usual Residence of Decedent	IX W 2										1404	Inside City Lim	aito
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and F show	5		Arundel	Gle	n Burni		- 1-				10a Citiz	en of Wha	it Country?		
Maryl r 28a-ed at c	Director	10e. Street and Number				10f. Zip C						U.S.A			
er death with the Maryland or items 23a or 28a-f show any must be notified at once.		5 Beach Road 11. Marital Status	12 Was D	ecedent Ever in U.	S. 13. Wa	as Decedent	of Hispa	anic Origin	n? (Spe	cify Yes or N		14. Race -	American II	ndian, Black,	\dashv
sath wi	Funeral			Forces?	If Y	es, specify	Cuban, I	Mexican, F	Puerto R	tican, etc.)		White,			ŀ
fter de l'', or		3 Widowed 4 X	Divorced If Yes, Give Y			Yes 2X							White		
ours a	d by	15. Decedent's Education (S	pecify only highest gr		16a. Deceder during n	nt's Usual On nost of worki	ccupationg life. [on (Give ki DO NOT u	nd of wo	ork done ed)	16b. K	ind of Bus	iness/Indus	ту	
n 72 h	plet	Elementary/Secondary (0-1 12	2) College	(1-4 or 5+)	Bagg	gage H	land:	ler			A	irlin	nes		
-00. I withingiene.	Completed	17. Father's Name (First, Mide	die, Last)					8.Mother's		First, Middle					
21215-0036 Muld be filed within 72 hours after death with the Maryland Mantell Hygier other than "natural", or items 23a or 28a-f she re event, the Medical Examiner must be notified at once	Be C	Dennis Gaffn								Ellen				0.11	-
21 nould bed Mer is mar tic ev	1º	19a. Informant's Name/Relation		/ar . 1	19b. Mailir	ng Address	(Street	and Numb	per or Ri	ural Route N urnie	umber, Ci MT)	ty or Town 21060	i, State, ∠ip)	Code)	
MD nd 2 sho alth and m 27 is		Mrs. Sheila 20a. Method of Disposition	E. Gattney	/Mother	Place of Dispo			eterv.		Date			City or Tow	n, State	\dashv
Baltimore, permit. Pages 1 an Department of Hee Important: If ite injury or other tr		1 Burial 2 X Crema	tion 3 Remova	I from State	crematory or o	ther place)			Nov 20	. 20,	St	evens	sville	. MD	
t. Pag tment tment rtant:		4 Donation 5 Other 21. Signature of Fineral Serv	Specify:	1.7										mation	\neg
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ex		1/1/1	-	401411	S	ervice	es 1	Seco	ond .	Avenue	s SW	Glen	Burni	Le MD 2.	1061
Physician		23a. Part I. Enter the disease failure. List only one ca	, or complications tha	t caused the death	n. Do not enter	the mode of	dying, s	such as ca	rdiac or	respiratory	arrest, sho	ock, or hea	art A	pproximate Inte Between Onset Death	
/Medical aminer		Immediate Cause (Final dise	ase a. Heroir	intoxicat		*		_				_			
		or condition resulting in deat	n) Due to (or a	s a consequence	of):										
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x 68 h certi tendin	isi	past 12 months?	9.7	egnant at time of o	leath 5	Other (Spec	cify)								- 1
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Divisior Hospital or Attend 24 hours after death Funeral Director:		4 Homicide	ng Physician: To the		d at hom		timo d	late and al	ace and		_				
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Purearal Director. After this certifi completely filled in by the funeral director.	le di	29a. Certifier 1 Certifyi (Check only one) 2 Medica	Examiner:On the ba	asis of examination	and/or investi	gation, in my	y opinior	n, death o	ccurred	at the time,	date and p	olace, and	due to the o	;ause(s)	
To the within To the complet	Medical	29h Signature and title of c	and manr	ner stated.				se number						n, Day, Year)	
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		30. Name and address of po							-W:		1204				
		Patricia Aronica-P		sistant Medica			enn S	treet, B	aitimo	re, MD 21	1201				
Regi	Stat			2. Registrar's Sign	ature	E .									
Reg	كاليت	110120	FAA. 2-100	-	-										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 14, 2007 **Physician** Noriko Girvin 2:20p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6781 Haviland Mill Road Howard Clarksville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 1 M 2000 Director March 18, 1922 575-50-83<u>3</u>5 Japan Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ?7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2\\ No Director Maryland Howard Clarksville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 6781 Haviland Mill Road 21029 United States of America Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes TVNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: ģ XX Widowed 4 ☐ Divorced Specify: Japanese Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 4 College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Important: If item 27 is marked other tha any injury or other traumatic event, the 1 once. Japan School System School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tomematu Daimon Tanei 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6781 Haviland Mill Road Clarksville, MD 21029 Lola D. Evans Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial Gardens Nov. 17, 2007 Finksburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. MOOSS 8728 Liberty Rd. Randallstown, MD 21133-4784 23a. Parl 1. Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** demonte disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or inju-that initiated events resulting in death) Last burial-trar ed by the attending physician and detached for use as the burial-trai Due to (or as a consequence of): Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery vas decedent pregnant 3 Ectopic pregnancy n the past 12 months? 1 ☐ Yes 2 ☑ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autonsv performe this certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification; To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; / completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifier 29c. License number

State Registrar

NOV 2 0 2007 | Alexander

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

USSELI C

31. Date filed (Month, Day, Year)

lavis, MAJ, MC

WRAMC

32. Registrar's Signature

ORIGINAL

Georgia Ave NW WASHINGTON DC 20307

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

Medical

State

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month; Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Bigistrar's Signature

LOSENTHAZ

Saltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

4940

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

QES-000

29d. Date signed (Month, Dav. Year)

EASTELN AVENUE BALTIMORE MD 21224

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Clinton George Hyman 11 13 2007 11:00a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2406 Loyola Northway Apt 203 Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 07 04 Birthplace (State or Foreign Country) ^{Year)} 25 Days 1 XM 2 ☐ F Months Hours Yrs. 82 NC 212-20-7579 Usual Residence of Decedent 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits MD NA Baltimore 1X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 2406 Loyola Northway Apt 203 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1√ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 【XNo Specify. Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Service Manager Trucking Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nathan Hyman Chanie Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2406 Loyola Northway Apt 203, Baltimore, Md Tillary Hyman-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Murial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet 11/20/07 Owings Mills, Md Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the rease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastat c months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Vonknown 1 TYes 2 TNo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation М 1 Tyes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

Examiner Box 68760 Records, P.O. Seorge Division or Vital

al or Attend after death. filled in by the To the Hospital within 24 hours a To the Funeral C

State Registrar

DHMH 17 Rev 1/2001

Physician

Examiner

Funeral

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medi al Exa<u>miner must be notified at</u>

within 72 hours after

2 should be f and Mental F

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any Injury or are.

Physician

/Medical

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funeral director, page 2 should

certificate I

After this

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

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Physician/Medical

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Completed

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Certification:

Medical

150 31. Date filed (Month, Day, NOV2 0

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Hospice 838 2. Registrar's Signature

ORIGINAL

29c. License number

D24170

N. EutawSt Baltimore MD 21201

29d. Date signed (Month, Day, Year)

November 19, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State	e of Ma	aryland		artmen <i>tificat</i>				ental Hy	giene Reg. No.	200	7	37	015
	Div. of all		1. Decedent's Name (First, Midd	le, Last)								2. Date of De. Month	ath Day	Ye	ar	3. Time of	Death
	Physici /Medic		Patricia Ann	Hu11								Novem				9:23	AM M
)	Examin		4a. Facility Name (If not institution	in, give street and	d number)			4b. City,	Town, or	Location o	of Death		4c.	County of D	eath		
			117 Mullen S							land				l1ega1			
	Funeral		5. Sociat Security Number	6. Sex 1 ☐ M 2 1√2			ast birthday) Yrs.	If Under Months	1 Year Days	tf Under	Min.	8. Date of Bird (Month, Da July 31	h y, Year)	9.	Counti	ce (State o	r Foreign
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	land ow		10a. State 10b. County	,		10c. City	, Town or Lo	cation							10	d. Inside Ci	ty Limits
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	r 28a	Director	10e. Street and Number	.6411)			, dillo e i	10f. Zip	Code				10g. Citiz	en of What	t Count	ry?	
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Maryland 21215-0036		To B	Grant Eugene 2	Zollner						Patr	ricia	Magui	re				
a Z	should to marke umaric	-	19a. Informant's Name/Relations	ship (Type, Print,)		19b. Mailin	g Address	(Street a			Route Number		Town, Star	te, Zip (Code)	- 1
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Baltimore,	Pages 1 and 2 should ment of Health and Mer ent: If Item 27 Ie marke ury or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 Clamous I	iram Ctata	20b. Pl	ace of Dispo	sition (Nar	ne of ther place	9)	Da	ate	20c. Lo	cation - City	or Tov	n, State	
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	/Medical Examiner		resulting in death)	Du	e to (or as	a consequ	ence (f):										
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<u>s</u>	tend leath tor: /	cat	2 Accident invest 3 Suicide 6 Could	igation not be				M		/es 2 □ I					-		
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	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 Medical one)	l Examiner: On t	he basis of	examinati	ion and/or inv	estigation,	in my op	oinion, dea	th occurre	d at the time,	date and	place, and	due to	the cause(s)
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			30. Name and address of person	who complet of	cause of d	eath (ttem	23а) (Туре.	Print)			-	V Service			-		
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	Registr	ar	NOV 2 0 20	07	Season .	H	Local										

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 2 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

210

BUSINESS

32 Registrar's Signature

DHMH 17 Rev 1/2001

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REISTERSTOWN.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

THM#5, per H. 08/5, I/10/08, WS

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month Year 58 **Physician** Margaret Hant 2007 11 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore Parkville Oak Crest Care Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Social Security N 224 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 216-07-7214 1 ■ M 2 F 90 Maryland Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show "natural", or Items 23a or 28a-f shov edical Examiner must be notified at Parkville Baltimore Maryland 1 □Yes Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with United States Of America 21234 8810 Walther Blvd.Apt. 2124 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Quban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or the any inlury or other traumatic event, the Medical Examine 1 Dever Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes PNo ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) N/A Elementary/Secondary (0-12) Real Estate Title Co. Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret E. Schackert Edwin C. Reisz Sr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17824 Foreston Rd. Parkton.Md 21120 19a. Informant's Name/Relationship (Type. Print) Milton Hartig- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Met od of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Nov 20,2007 Parkville, Maryland Parkwood 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee EVANS FUNERAL CHAPEL & CREMATIONS ERVICES 8800 Harford Rd. Parkville Maryland 21234 1 alware 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mesture d **Physician** /Medical Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician a Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 Fetal death Month Day Year 5 Other (specify) by the a 9□Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Johknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 s autopsy performed? page certificate 1□ Yes 2 LNO To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 1 ☐ Yes 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Beath 28c. Injury at Work? Medical Certification: After (Month, Day Year) Injury 1 Natural 5 ☐ Pending To the flowers after death.

To the Funeral Director: After the Funeral Director of the funeral by the funeral 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30, Name and address of parson who completed cause of death (Item 23a) (Type, Print) 8800 Walthy Blun Burnen That Mi 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 0 2007 Registrar

MARGaret

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Division or Vital Records, P.O. Box 68760,	E
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		1- For State Registrar Certificate of Death		2007 37	1018
Physicia	an.	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Da	3. Tin	ne of Death
/Medic	al	TRANK Elisworth HENDERSON	November	16# 2007 21	10 PM
Examin	er		40	c. County of Death	
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he Ma 28a-f s otifiec	Director	Maryland BALLimore	10- 0	itizen of What Country?	Yes 2□No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		10e. Street and Number 10f. Zip Code 1701 Eutaw Place Apt 801 2/2/17	10g. Ci	USA	
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and 2 ealth a n 27 Is	1 3	Christine Ella HEnder Son (daughter) 609 HARWOOD Ave Balti	noce MAR	yland 21213	<u>.</u>
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	calC	29a. Certifier 29a. Certifier (Check only (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.)	and due to the cause(s) and manner as stated.	uso(s)
the H hin 24 the Fi	Medical	and manner stated.			
To cor	=	29b. Signature and title of certifier. Pennifer Durphy, m.D. PES ac		ate signed (Month, Day, Ye	,
4	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	7004	Unio 10 , s	, ,
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Registra MH 17 Rev 1/20					

DH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 9:56 PM November 16 2007 taney Anthon 4 /Medical 4a. Facility Name (Khot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore The Johns Hopkins Hospita If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) Social Security Number (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F 216-96-5981 32 Aug. 12, 1975 MD Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at Baltimore MD 1∰Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or a mortant: If Item 27 is marked other than "natural", or items 23a or a win injury or other traumatic event, the Medical Examiner must be nonce. 21218 USA 1510 East 28th Street Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 🏹 No If Yes, Give Year or Dates: 1 Never Married 2 Married African American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) self - employed entrepenuer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carolyn Gilbert Anthony N. Haney, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7903 Brookford Circle Apt. F; Baltimore, Maryland 21208 19a. Informant's Name/Relationship (Type. Print)
Patricia Condrey / Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 11/19/2007 Randallstown, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signatule of Funeral Service Licensee Wylie Funeral Home, P.A. 21217 638 North Gilmor Street; BAltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Brain Physician Anoxic week /Medical Due to (or as a consequence of): Examiner 1do car Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 sl autopsy 1☐ Yes 2 **2** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Mnpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760. n 24 hou. the Funeral Dire 2

> State Registrar

29b. Signature and title of certifier

Paller

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

November 16, 2007 RES-000

600 North Worfe Street Baltimore Mary land 21287

29d. Date signed (Month, Day, Year)

The Johns Hopkins Hospital
2. Registrar's Signature 31. Date filed (Month, Day, Year)

NOV 2 0 2007

29c. License number

DHMH 17 Rev 1/2001

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			For State	State of Ma	rylan				Mental Hy	_	71111	37021
			Registrar 1. Decedent's Name (First, Middle, Last,)	-	Ce	rtificate of	Death	2. Date of D	Reg. No	ر ٥٥٠	3. Time of Death
i i i	Physici		Vicky Arlene						Month Nov.	Da	2007	4:09 A. ^M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of Deat			c. County of Deal	
				Stella Maris Hospice Timonium							altimor	
	Funeral	1 M 257 F								rth <i>ay, Year</i>) 1	9. Birt	hplace (State or Foreign ountry)
	Director		Usual Residence of Decedent		45				pan.	21,	1902 V	iriginia
	tryland show	L	10a. State 10b. County			y, Town or Lo						10d. Inside City Limits
	he Ma 8a-f s otifie	Director	Maryland Baltimo	ore	N	loodla				10= 0	itizen of What Co	1 Tyes 2 No
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If file It is marked other than "natural", or items 23a or 28a-f show if if them 27 is marked other than "natural", or items 2 be notified at or other traumatic event, the Medical Examiner must be notified at	١٥	10e. Street and Number 6728 Yataruba Di	cive			10f. Zip Code 2120	7		US		ountry :
	death ms 2: r mus	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.	S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S	Specify Yes or N	0-	14. Race - Ame Black, Whit	
9	after or ite	/ Fu	1 Never Married 2 Married	1 ☐ Yes 24 ☐ N If Yes, Give	0		1 ☐ Yes 2 ☑ No		to nicali, etc.)		Specify: B1	
21215-0036	hours tural", al Exa	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:			dent's Usual Occur			16h I	Kind of Business/	
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212	d with giene er thau	Completed	Elementary/Secondary (0-12)	1 year	-)	Dieta	ary Aide	2		Re	estaura	nt
nd	be filed tal Hygi d other event, tl	Be (17. Father's Name (First, Middle, Last)						me (First, Middle		,	
Maryland	2 should be to and Mentail is marked of raumatic eve	۴	Willard Emery 19a. Informant's Name/Relationship (T)	ma Drint)		10h Maili	ng Address (Street	Willie				Zin Cada)
Ma	and 2 sho ealth and n 27 is ma ier trauma		Willie Mae Sing		othe	1	_					
ē,	is 1 and 2 of Health item 27 i		20a. Method of Disposition		20h D	lace of Dien	neition /Name of		Date	200 1	onation City or	Town State
<u>m</u>	Pages nent of h ant: If ite ury or of		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		Woo	odláwi	n Cemete	ery 11/	20/07 1	1000	dlawn,	Maryland
Baltimore,	permit. Pages 1 a Department of Hee Important: If item any Injury or othe		21. Signature of Funefal Service Licens	ee								neral Home
	0 - 4 O	2	To Part I Ster the disease or comp	lications that caused	the death						_IMOIE,	Md 21215 Approximate
	Dhysisian	-	a. Part1. Fiter the disea 1, or comp ships, or heart failure. List only o Immediate Cause (Final				tor the mode of dyn	ng, odon do odrđio	ic or respiratory	arroot,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a								
i.	Examiner	,	Sequentially list conditions.	b								
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequ	uence of):						
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89	The law requires that the death certificate be tee has been signed by the attending physicis age 2 should be detached for use as the but	Physician/Medical	IF FEMALE:									
Вох	ath of	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at	2 🗌 Feta	I death 3[⊒Ectopic pregnanc ⊒ Other (specify) _	ÿ			23d. Date of de Month	livery Day Year
P.O.	that the de led by the a detached 1	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown	9□Unknown	unie or u	eatii 5t						
<u>ر</u> ر	uires that signed b d be deta	by Pł	Part II. Other significant conditions co	ntributing to death bu	t not resi	ulting in the u	ınderlying cause giv	ven in Part I.	23e. Did	tobacco	use contribute to	o the cause of death?
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			0-11						1□ Yes			s 2□No
ξ	rsicial s certii lirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 □ Inpatier	 nt 2□	ER/Outpatie	nt 3□ DOA Oth	nor.	eath <i>(Check only</i>		6 KlOther (Sne	ecify) HOSPICE
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Sior	Attending Ph or death. ector: After th by the funeral	atio	2 ☐ Accident investigation				M 1	Yes 2 □ No				
Division or Vital Records,	I or Att after d Direct d in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju building, etc	ry - At ho . <i>(Specif</i>	ome, farm, st y)	reet, factory, office		28f. Location City or To			ural Route Number,
ш	spital ours a neral filled		29a. Certifier 1 Certifying Phy	sician: To the best o	f my kno	wledge, dea	th occurred at the ti	ime, date and plac	e, and due to th	e cause	(s) and manner a	s stated.
	To the Hospital or Attending Physician: whim 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	one)	iner: On the basis of and manner sta		ition and/or ir			curred at the time	e, date a	nd place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier				29c. Licens			29d. D	ate signed (Mon	
,	V 1				māla /ā·	- 00s) (T:::	Orint)	4372	7			5/07
L	'		30. Name and address of person who c DR. TARIO MAHMOOD	ompleted cause of de				'IMONIUM,	MD 210	93		
75	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signa	ature		THUM TUFF	TID ZIO	/		
	Registr	ar	NOV 2 0 2	007 June	Sud .	15 P	podu					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Approximate Interval Between Onset and Death YRS.

23d. Date of delivery Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated.

Registrar

State

The state of

37022 2007 8:00 P.M

9. Birthplace (State or Foreign 1936N.Carolina

> 10d Inside City Limits 1XYes 2 No

10g. Citizen of What Country?

14. Bace - American Indian Black, White, etc. Specify Black

16b. Kind of Business/Industry Maryland Vehicle Administration

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 79 N. Culver Street Baltimore, Maryland

20c. Location - City or Town, State Owings Mills, Md

22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215

29b. Signature and title of sertifier

NOV 2

29d. Date signed (Month, Day, Year)

no completed cause of death (Item 23a) (Type, Print) ROSEMARY 30. Name and address of person PLACE BURKE312 PAUL 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 37023 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Year 35 Carrie Jones 11 900 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner BALT AGNES HOS P BALT MORE

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min TAL Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F 76 Director 240-44-6217 05/08/1931 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show a or 28a-f show t be notified at Director 1 Yes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a U.S.A. 22 South Athol Funeral Avenue Pages 1 and 2 should be filed within 72 hours after death 21229 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 Never Married 2 Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black þ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maggie William Ben Edmond 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trai once. 3310 Glen Avenue, Baltimore, Maryland Elizabeth Clark / Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Mt. Zion Cemetery 11/24/2007 | Landsdowne, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service License 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Vist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NEUMONIA Inknown /Medical Due to (or s a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner RESPIRATORY FAILURE and Due to (or as a consequence of): physician The law requires that the death certificate be by Physician/Medical attending physic 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DECUBITUES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📆 🔨 Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the f 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)

Division or Vital Records, P.O. Box 68760,

H

State Registrar

AHMEI 31. Date filed (Month, Day, Year)

NOV 2 0

32. Registrar's Signature

821 N. Eulaiv

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			- FOI	partment of Health and Menta	10050 5000!
	21		1. Decedent's Name (First, Middle, Last)		Reg. No. 2 3 3 4 te of Death 3. Time of Death
į.	Physicia /Medic		ELIZABETH ROGERS JAHNCKE		vember 17, 2007 1:02 A
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
100	Funeral		ROLAND PARK PLACE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		te of Birth Onth, Day, Year) N/A 9. Birthplace (State or Foreign Country)
L	Director		437-14-3203 1 M 2 N F 87 Yrs.		onth, Day, Year) Country) OV 3, 1920 Tennessee
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	e Man 3a-f sh tifled	Director	Maryland N/A Balt:	imore City	1 ∑Yes 2 □ No
	flied within 72 hours after death with the Maryland Hygiene. kther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at		10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	death ms 23	Funeral	830 West 40th Street 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21211 Was Decedent of Hispanic Origin? (Specify Yell f Yes, specify Cuban, Mexican, Puerto Rican,	USA es or No- 14. Race - American Indian,
92	or ite		1 Never Married 2 Married 1 Yes 2 M No	1 ☐ Yes 2 No Specify:	etc.) Black, White, etc. Specify: White
Maryland 21215-0036	hours Itural"	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Dece	edent's Usual Occupation	16b. Kind of Business/Industry
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27	iled wi Hygien Iher th nt, the	Co	17. Father's Name (First, Middle, Last)	oprietor	Antiques Shops Middle, Maiden Surname)
and	ould be f Mental H a rked ot atic eve	To Be	Robert Griffin Rogers	Ella Maye	Ramsey
ary	and and sum	-		ling Address (Street and Number or Rural Rout	
e, ≥	Health tem 27		Phillip B. Jahncke (Husband) 830 20a. Method of Disposition 20b. Place of Disp	West 40th Street, Bal	timore, Maryland 21211
nor			I Burial 2 Xi Cremation 3 Hemoval from State	ematory or other place)	
Baltimore,	permit. Pag Department Important: I any injury o	1	21. Signatur 1 Fun of Service Rice Service	Name and Address of Facility ATTCHELL-WIEDEFELD FUN	007 Baltimore, Maryland
m	B B E E	ie d	, rial citi b. Lawson	DOUG York Road, Baltin	nore, Maryland 21212
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final	1	iratory arrest, Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	myelomA	5 years
1/4	Examiner				
7	ed	iner	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury		
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Box	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as it	Physician/Mec	in the past 12 months? 1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
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Vital Records,	w requ	Completed		2	4a. Was an 24b. Were autopsy findings available
Ä		ошо			autopsy performed? death? ☐ Yes 25 No 1 ☐ Yes 2 ☐ No
/ita	nysician: Th nis certificate I director, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (Che	
o	Physi r this c rral dir	<u>۲</u>	1 Yes No Hospital: 1 Inpatient 2 □ ER/Outpatie 27. Manner of Death	- I - I - I - I - I - I - I - I - I - I	☐ Residence 6 ☐ Other (Specify) escribe how injury occurred
<u>o</u>	ending Phy ath. rr: After thi ie funeral d	ation	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
Division or	I or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)		cation (Street and Number or Rural Route Number, ty or Town, State)
	spital of ours at peral Differential Differe		29a. Certifier 11 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, and du	ue to the cause(s) and manner as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director, i	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.		
	To t withi To tl	ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
)		4	20 Name and addition of agreements assurant as the first of a		Novem BEr 17 200-
	5	ķ.	30. Name and address of person who completed cause of de th (Item 23a) (Type Hilary Don, MD, 830 West 40th Stre		nd 21211
	Sta		31. Date filed (Month, Day, Year) 32 Degistrar's Signature	and the second s	
	Registr	aı	NOV 2 0 2007 Beauty 18 18	good &	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 8875 1-23-08 yt State of Maryland Poepartment of Health and Mental Hygiene Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 15:03 PM Howard Johnson NOVEMBER 14 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SINAI HOSPITAL OF BALTIMORE BALTIMORE n/a | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 12-7-1927 Birthplace (State or Foreign Country) 5**217**-516-4535 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1∏M 2□F 84 MD Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. Count 10c. City, Town or Location 28a-f show traumatic event, the Madical Examiner must be notified at 1 X Yes 2 □ No Director MD Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 927 N. Rosedale Street 21216 USA 238 Funerai deeth 12. Was Decedent Ever in U.S. Agned Forces? 1 ÑYes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or Iteme 1 Never Married 2 Married Specify: African-American Baltimore, Maryland 21215-0036 1 Yes 2 No δ 3 ☐ Widowed 4 ☐ Divorced "netural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **Oustodian** Baltimore School Systems 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ie marked of Charles Johnson Ella Purnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i laJene Johnson / Son 4209 Norfolk Avenue, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H important: if its any injury or ot 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Veteran 11-21-07 wines Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. sandar 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RENAL FAILURE ZYAU disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner VASCULAR DISEASE MEARS PERIPHERAL Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown this certificete has been signed to director, page 2 should be detent Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 PYes 2 No 3 Probably 4 Unknown CORONARY ARTERY DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CEREBRO VASCULAR 24a. Was an DISTASE autopsy performed: 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1√0 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

the Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. After this certification funeral director, s effer dea. within 24 hours eff
To the Funeral Di
completely filled in

TOFFINAN HOWARD

Certification: To 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of

SURGEON

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D41129

29d. Date signed (Month, Day, Year) NOVEMBER 15, 2007

21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

eta N. Cho MD

PETER W. CHO SINAT HOSPITAL 2401 WEST BELVEDERE AVENUE, BALTIMONE, MARYLAND

State Registrar

Medicai

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year) NOV 2 0 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 11 per moth 98773-14-08 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2007 SharonM Jones 14 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bultimore Baltimore Good Samarifan Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 50 1 ☐ M 2 □ ▼F 1-7-1957 Director **214-64-813**8 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 XNo Parkville Baltimore Director MD10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21234 6863 McClean Blvd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 1. Never Married 2∑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: African-American ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Housing Authority 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pauline Richards James A. Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 102 CampSprings Court, Owings Mills, MD 21117 Carroll A. Holmes/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-20-07 Woodlawn, MD King Memorial Park 22. Name and Address of Facility Wlie Fineral Fine F.A. of Baltimore G. 21. Service Licensee 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or a. a consequence of): **Physician** /Medical ferion and Pneumonia Examiner Urinay Tract Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transi liver Cirrhos Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 No 1∐ Yes e Hospital or Attending Physician: 24 hours after death.

2 Hours after death.

e Funeral Director: After this certifica letely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Wei Cier. M.D. RES 000 11/14/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 21239 Bird 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- State Amend 10e&19b, perFH, g873, 11/20/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 11:36 а. м Carlyle Edison Joines November 2, 2007 /Medical 4c. County of Death Howard 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Highland 13285 Clarksville Pike Date of Birth (Month, Day, Year) March 31, 1924 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours North Carolina 83 Yrs. 241-24-9927 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2 No Highland Howard Director Maryland 10g. Citizen of What Country 10e. Street and Number 13285 Clarksville Pike 10f Zin Code 20777 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
11 Yes, Give 194
Year or Dates: 194 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. 1943 Specify: White Completed by 3 Widowed 4 □ Divorced 1945 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fine Woods Buyer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leva Mahala Joines Carl McKinley Joines 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19285 Clarksville Pike Highland, Maryland 20777 19a. Informant's Name/Relationship (Type. Print) Mrs. Louanne J. Collison Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore, MD Bayview Crematory 11.5.07 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Ucensee 22. Name and Address of Facil Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anula of Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to limite liats cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duri to (ones a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown rumo wary Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ HO 24a Was an autopsy performe 1 Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After t 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funeral Dire o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certified death (Item 23a) (Type, Print) 32. Registrar's Signature Musor, m COURT FUINE LOS 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dorothy Catherine Kahler /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. Examiner nseaal auare TIMOVE 8. Date of Birth (Month, Day, Year) October 26 1911 7. Age (In yrs. last birthday) if Under Months 9. Birthplace (State or Foreign Under 24 Hrs. Social Security Number Funeral Days Hours Min. Baltimore Co., Md. 1□M 2□F 96 216 46 6280 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ortant; If item 27 is marked other than "natural"; or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Baltimore Baltimore County Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 USA 6630 Kenwood Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No þ Specify: Specify: White 3∕X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Magnee." Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping...own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Shafer Conrad Winterstein ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) No 202 Timonium, Md. 21093 Robert G Kahler 1 Baratra Court 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XI Burial 2 ☐ Cremation 3 ☐ Removal from State November 21 2007 Gardens of Faith Cem. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lassahn Funeral Home Inc 21. Signature of Funeral Service Ligensee 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 01 1my05H15 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): ed by the attending physician detached for use as the bunal Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes Leuhemic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 힏 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director; completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier t 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

D0058371

Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000

Drive Baltimore, 4nd 21237 tranklin

3 Registrar's Signature 2007

Sanda

29b. Signature and title of certifier

			1 - State Amend Item 2	State of Ma 23a per d	aryland r.,g8	d / Depa 374 - 2 97	rtment of H /06/07dbt ///care of	lealth and Death	Mental Hy	rgiene Reg. N200	7	37029
	Physici /Medio		1. Decedent's Name (First, Middle, Last) David Keitz	:					2. Date of Do Month NOV •	15 20	3° 7 °	3. Time of Death 6:22a M
	Examir		4a. Facility Name (If not institution, give s Stella Maris Ho				4b. City, Town, or		ith	4c. County of Bal		ore
	Funeral Director		5. Social Security Number 6. Sex 218-44-4309	7. Age M 2□F	61	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	8. Date of Bi (Month, D Dec.	rth ay, Year) 14,1946	Cour	lace (State or Foreign atry) cyland
	aryland show	٥٢	Usual Residence of Decedent 10a. State 10b. County MD Baltimo	re	10c. City	Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 🎢 No
	with the M a or 28a-f be notifie	Director	10e. Street and Number 356 Oberle A				10f. Zip Code 212			10g. Citizen of W	hat Cour	
36	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? Yes 2 N If Yes, Give Year or Dates:			 Vas Decedent of H f Yes, specify Cuba I □ Yes 2 🎛 No	ispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)		- Americ , White,	
21215-0036	vithin 72 hou sne. than "natura te Medical E	Completed I	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5	+)	(Give life. L	lent's Usual Occup kind of work done o DO NOT use retired TON WOY	during most of w	orking	16b. Kind of Bus	siness/In	dustry
land 2	be filed Ital Hygi d other event, <u>t</u>	To Be Co	17. Father's Name (First, Middle, Last) David Keitz	2yrs			TON WOL			, Maiden Surname	·)	
Maryland	L	F	19a. Informant's Name/Relationship (7)/19 Gail Keitz /wif	•			-			ber, City or Town, S		,
altimore,	permit. Pages 1 and 2 Department of Health Important: if item 27 i any injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 A 4 Donation 5 Other (Specify)		20b. Pl	ace of Disposemetery, cren	sition (Name of natory or other places of Fai	:e)	Date /19/07	20c. Location - 0	City or To	own, State
Baltii	permit. I Departm Importar any Inju		21. Signature of Funeral Service License	ROMA		22	Name and Address	ss of Facility 3	00 Mace	e Ave.Ba ne_of Es	alto	. MD
58760, 7	Physician and bubysician and strength strength is the burial-transit	edical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Understand Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	SEAS a consequ a consequ	ence of):	er the mode of dyin		ac or respiratory :	arrest,		Approximate Interval Between Onset and Death
O. Box 68	death certi e attending d for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth the dillergnant at the second sec	2 🗌 Fetal	death 3	Ectopic pregnancy Other (specify)			23d. Date Mon		ery Day Year
ds, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions cor	tributing to death bu	ut not resu	Iting in the ur	nderlying cause give	en in Part I.		tobacco use contri Yes 2 □ No		
I Records,	The larate has	Completed							24a. Was auto perf	opsy promed? promed?	rior to co eath?	psy findings available mpletion of cause of
VIta	sician certifi rector	Be	25. Was case referred to medical examiner?	ospital:		-7/0 : "	Oth		eath (Check only	one)		
Division or	nding Phys th. : After this s funeral di	ition: To	1 ☐ Yes 2 😿 No ☐ Control of Death 1 🛣 Natural 5 ☐ Pending 2 ☐ Accident investigation	1 Inpatier 28a. Date of Injur (Month, Day	ry	ER/Outpatien 28b. Time of Injury	28c. Injur Worl	4 Li Nursing		how injury occurre		W HOSPICE
DIVIS	To the Hospital or Attending within 24 hours atter death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju building, etc	iry - At hor c. (Specify	me, farm, stre	eet, factory, office		28f. Location City or To	(Street and Number wn, State)	r or Rura	al Route Number,
	To the Hospital or Al Within 24 hours after of To the Funeral Direc completely filled in by	Medical (29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examination		examinat							
1	To ti Withi To ti	M	29b. Signature and Itle of certifier				29c. Licens	e number	_	29d. Date signed	(Month,	Day, Year)
,	4		30. Name and address of person who co	mpleted cause of de	eath (Item	23a) (Type, I	Print)	1165		1//	15/0	/
	Sta	te	DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)	2300 DU 32 Registra	r's Signat	ure		MUINOMI	, MD 210	93		
	Registr		NOV 2 0 200	7 Marie	e de	do	West of					

6:22 a.m.

NOVEMBER 15, 2007

DAVID KEITZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 37030 State of Maryland / Department of Health and Mental Hygien 17 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year II**Physician** 05:30 AM rances, 2007 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Hospital Samaritan 8. Date of Birth DEC • 2 1911 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days Hours Maryland 1 □ M 2 □ MF 96 218-26-9701 Yrs. Director Usual Residence of Decedent 10d, Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State 77 is marked other than "naturel", or items 23e or 28a-f show treumatic event, the Madical Examitrer must be multiled at 1 Yes 2 No Baltimore Essex ND Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 810 Mace Avenue 21221 USA Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or the of Health and Mental Hygiene.
Int: If item 27 Is marked other than "naturel", or Item 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Specity: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 ØWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 8th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Joseph Weinhold Anna Rupp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 810 Mace Avenue Baltimore MD 21221 Marlene Bosse /daughter Health item 27 I 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 11/17/07 Baltimore MD permit. Page Department of Important: If any injury or pnce. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave, Baltimore MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Asistole minutes Physician /Medical Due to (or as a consequence of): ardiovascular collapse Examiner hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Atherosclarotic Cardiovascular Pisage years physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed Cancer 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b irector, page 2 sl has 1□ Yes 2⊠ No 1 Yes 2 No Shinalos 25. Was case referre to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No s after de... death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 164 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11, 13, 2007

4

State Registrar 31. Date filed (Month, Day, Year)

Srd

GIPH BUTHI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 21061

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 13, 12:25 1 M 2007 Kirby /Medicat 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore University of Maryland Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 XM 2 ☐ F Hours 218-20-1023 80 July 24,1927 Washington, D.C. Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits Baltimore, Maryland 21215-0036 لالمب الجنحام a or 28a-f sho 1 ☐ Yes 2 No Director MDAnne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 "natural", or items 23a 908 Princeton Terrace U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Specify: White 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Military Traffic Elementary/Secondary (0-12) College (1-4or 5+) Management Command the 4 Business Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Emily Lippman Walter Kirby permit. Pages 1 and 2 st Department of Health and Important: If item 27 is ma any Injury or other traums once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 908 Princeton Terrace Glen Burnie, MD 21060 Mrs. Gloria Kirby / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 17, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 2007 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee M01479 Services 1 Second AVenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Elevation Physician ST disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year 4☐Pregnant at time of death P.O. 1 ☐ Yes 2 ☐ No by the 9☐Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 9 Cardiogenia Shock 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No page 2 autopsy performe certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Manpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division To the Hospital or Attending 5 ☐ Pending investigation 1 XNatural within 24 hours after deau.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1063617413 November 13, 2007 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimora, 22 5. St. Greene Jasonoh

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

NOV 2 0 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Knox 910 A M Nathaniel November 2007 11 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital Baltimore Citi If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Dec 7, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Sex Age (In yrs. last birthday) **Funeral** 1 ₹ M 2 □ F 216-54-4101 54 Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or 3 21201 1111 Park Avenue #309 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hyglene. The structural, or Items 23 ant; if Item 27 is marked other than "natural", or Items 23 ury or other traumatic event, the Medical Examiner musts Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 disabled bnone 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nathaniel Tanny Knox Pauline Rose Baldoe ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Knox Sr/brother 1111 Park Avenue #309 Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of important: If Its any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Licens e 21. Signatury of Funeral Service Ronal 1 22. Name and Address of Facility irector State Anatomy Board 655 W. Baltimore Street 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Physician pneumoma month resulting in death) /Medical Due to (or as a consequence of): Examiner years HIV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last tie to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-trans Exami Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2☐No 9□Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. δ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2□No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: after death.

Director: After this certific
In by the funeral director, within 24 hours aft To the Funeral Di completely filled in

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

29b. Signature and title of certifier

29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

medical doctor

RES-000

November 11,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

The Johns Hopkins Hospital, 600 N. Wolfe St, Baltimore, MD 21287 Janice Leung 31. Date filed (Month, Day Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

NOV 2 0 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physici		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	DayYe	3. Time of Death 3:35 A. M
	/Medic Examin	al -	Mary A. Kane 4a. Facility Name (If not institution, give street and number) Future Care Homewood		4b. City, Town, or Balt:	r Location of imore	November	4c. County of D	
	Funeral Director		5. Social Security Number 212-05-0100 6. Sex 1□ M 2□ F 90	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of Birth (Month, Oay Sept. 3	9. (Year) 0,1917 Ma	Birthplace (State or Foreign Country) aryland
	Maryland a-f show illed at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, To Maryland N/A		cation altimore				10d. Inside City Limits XXIYes 2 □ No
	with fhe	Dire	10e. Street and Number 500 W. University Parkway 11M		10f. Zip Code 21210			10g. Citizen of What USA	Country?
936	within 72 hours affer death with fhe Maryland ene. then "returel", or Items 23e or 28a-f show the Madical Examinar must be notified at	by Funeral	11. Marital Status XXNever Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No II Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2☑ No	lispanic Orig an, Mexican, Specify:	in? (Specify Yes or No- Puerto Rican, etc.)		vmerican Indian, Vhite, etc. White
21215-0036	be filed within 72 ho fal Hygiene. d other then "netur event, he M.d.t!	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired inting Of	during most d)	of working	16b. Kind of Busine	ne Company
N	be filed fal Hygi d other event,	To Be Co	17. Father's Name (First, Middle, Last) Joseph L. Kane	10000	arcing or	18. Mother	's Name (First, Middle, elen M. Fis	Maiden Sumame)	ic company
Σ	# 1 3 d	Ĕ	19a. Informant's Name/Relationship (Type, Print) Helen A. Kane Sister				or Rural Route Numbe Parkway 11i		re, Zip Code) re, MD 21210
Baltimore,	age ent o ht: If ry or		1 Rusial 2 Commation 2 Pamousl from State	itery, crei	sition (Name of natory or other place edral Ceme		Date 11/20/2007	20c. Location - City Baltimore	or Town, State e, Maryland
Balt	permit. P Departm Importer any injui		21. Signature Fineral Service Licensee Augm B. Hinss	E	3631 Fall	nss-Se s Road	eitz Funera 1. Baltimor	e. Maryla	nd
	Physician	1 10	23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a.		er the mode of dyin	ng, such as o	cardiac or respiratory an	rest,	Approximate Interval Between Onset and Death
ij.	/Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injusy that initiated events resulting in death) Last Due to (or as a consequence of	ce of):	<u>~</u>				unlesen
.O. Box 68760,	The law requires that the death certificate be executed to be assetted to the stending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medical B	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) Vo 9 \(\text{Unknown} \) Unknown		□Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
rds, P.	w requires fhaf been signed by should be defa	b	Part II. Other significant conditions contributing to death but not resulting	g in the u	nderlying cause giv	en in Part I.			te to the cause of death? Probably 4 \(\frac{1}{2} \) Unknown
of Vital Records,		Completed					24a. Was autop perior	sy prior	
Vita	sicien: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/	· · · · · · ·	oth 20 DOA Oth	an .	of Death (Check only o		Canada)
	ling After fune	atlon: To		b. Time o Injury	f 28c. Injur War	y at		now injury occurred	эреспу)
Division	tel or Attencts after death al Director: ed in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	, farm, sti	reet, factory, office		28f. Location (S City or Tow		r Rural Route Number,
	To the Hospitel or within 24 hours after To the Funeral Director Completely filled in I	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowled to the best of my knowled to the best of examination and manner stated.		vestigation, in my o	pinion, deat	h occurred at the time,	date and place, and	due to the cause(s)
12	To the within 2 To the complete	Σ	29b. Signature and title of certifier Dalycet School MO	7	29c. Licens	e number		29d. Date signed (M	
6	3		30. Name and address of person who completed cause of death (Item 23		Print)	Royce	Ae B	CH ND	2(21)
	Sta Registi		31. Date filed (Month, Day, Year). NOV 2 0 2007	1	perti				

3:35 A.M.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** November 17, ANNE MARIE McGINN KEENAN 2007 2:10 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore County 205 East Joppa Road, #208 Towson If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🕱 F 66 Sept 1, 1941 Maryland Director 212-40-8303 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner muse to be approximated. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Director Maryland Baltimore County Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 **USA** 205 East Joppa Road, #208 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify. Specify: White þ 3 □ Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medical Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cornelius Thompson McGinn Elizabeth Anne Matthews 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 24 Club View Iane, Phoenix, Maryland 21131
of Disposition (Name of Date 20c. Location - City or Town, State Sean J. Keenan, (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem Grdns 11/21/2007 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur, i Eurevil Service Vicebeer www MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Tulmonar disease or condition resulting in death) /Medical Due to (or as a conseque ce of): 18mus Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-trans Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE nse 23c, If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year ō 5 Other (specify) Division or Vital Records, P.O. the 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 2 No 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 🔲 Yes 2 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death After 1 Certification: 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 6 ☐ Could not be 28e. Place of injury At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical ExamIner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H 53088 November 19,2007

12

Registrar

31. Date filed (Month, Day, Year) State NOV 2 0



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOV. 4:26 A. **Physician** 2007 Betty Lee Keigley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford County Havre de Grace Harford Memorial Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🗶 F 80 219-20-8427 22,1926 Maryland Director Dec. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2X No WY Platte Guerresy Guernsey Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be result. United States 82214 350 North Kansas Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 140 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home N/A Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Victor Louis Tyeryar Nellie Lerore Swomley 19b. Mailing Address (Street and Number or Rural **Gujetingsey**ty or Town, State, Zip Code) 348 North Kansas Avenue, Guernesy, WY 82214 19a. Informant's Name/Relationship (Type. Print) Mr. Stephen Keigley (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, Maryland 11/15 2007 Evans Funeral Chapel 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility

Evans Funeral Chapel & Cremation Services - Bel Air 21. Signature of Funeral Service Licensee Jer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3 Newport Drive, Forest Hill, Maryland 21050 Immediate Cause (Final disease or condition resulting in death) Physician Intra Abdominal days /Medical Due to (or as a consequence of): Examiner Bowel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Multiple Abdominal Due to (or as a consequence of) the burial-Division or Vital Records, P.O. Box 68760, physician Physician/Medical as t attending p IF FFMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No Month Day 5 Other (specify) as been signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Frifarction Myscardial 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been Renal Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Adhesions Partial Small Bowel of certificate LYSIS Resection 2 No 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural
2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ho completed cause of death (Item 23a) (Type, Print) 50/ S. Union Ave. 30. Name and address of person Parco Harre de Grace, Maryland amora, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

NOV 2 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 3:15 PM Paul George Kiel November 18 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Point Cecil VA MALY LAND HEALTH CARESYSTEM

5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) PERRY TO: der 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/27/1933 Birthplace (State or Foreign Country) **Funeral** Days 1**∑** M 2□ F 214-30-6585 Director Balt., Maryland KNOWN to physician! Kiel, Paul Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No 28a-f sh notified Maryland Baltimore Timonium Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or must be n United States 12030 Tralee Road Unit 105 21093 Funeral of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ★1 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. r than "natural", or Items the Medical Examiner mu 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2**XX**Mo Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineering 12 Equipment Designer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Emma Sunderland Jerome Edward Kiel 2 19a. Informant's Name/Relationship (Type. Print) Companion 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 093 Marguerite Z. Schwiebert/ 12030 Tralee Road Unit 105 Timonium, Maryland permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other troonce, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition ty⊋Burial 2 ☐ Cremation 3 ☐ Removal from State November 4 ☐ Donation 5 ☐ Other (Specify) 21, 2007 Timonium, Maryland 21. Signal of Pineral Service License LAME Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Anteny Disease **Physician** UNKNOWN /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Mellitus Type 2 DiAbetes Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acrident (Stroke) Drovascular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No To the Hospital or Attending Prystean. within 24 hours are death.

To the Funeral Director: Aler this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 X inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 18,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VAMARYLAND HEALTH CARE SYSTEM PENY POINT MODIFOL Or A. HAShmi M.D. 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 0 2007

		1 - For State of Maryland / Dep	partment of Health and Nertificate of Death	_	ene 1-No.2007 3703
Physicia		1. Decedent's Name (First, Middle, Last)	KOGAN	2. Date of Death Month NOVEMBER	Day 2007 3. Time of Death 9:35 P N
/Medic Examin	< 1	4a. Facility Name (If not institution, give street and number) DOVE HOUSE	4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death CARROLL
Funeral Director		5. Social Security Number 220-39-7783 6. Sex 1 M 2 F 7. Age (In yrs. last birthda 80 Yrs.	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 10/06/19	9. Birthplace (State or Foreig
the Maryland 28a-f show otified at	Director	Usual Residence of Decedent		100	10d. Inside City Limit 1 □ Yes 2 N g. Citizen of What Country?
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral	1450 BEDFORD AVENUE APT. 417 11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give ▼ No	21208 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl		U.S.A. 14. Race - American Indian, Black, White, etc. WHITE Specify:
21215-0036 d within 72 hours af gliene. er than "natural", or the Medical Exami	Completed by	(Specify only highest grade completed) (Gi	redent's Usual Occupation re kind of work done during most of wor NO NOT use retired) ANICAL ENGINEER	king	6b. Kind of Business/Industry
Maryland 2 to 2 should be filed in and Mental Hygin to is marked other traumatic event, ti	ro Be C	17. Father's Name (<i>First, Middle, Last</i>) RUVIN KOGAN	18. Mother's Nar	ne (First, Middle, Ma	aiden Surname) PLATKOVA
e, Mary 1 and 2 shor Health and h em 27 is ma nther trauma			iling Address (<i>Street and Number or Ru</i> BENSMILL COURT - F		
Baltimore, permit. Pages 1 a Department of Hee Important; if item any injury or othe once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	22. Name and Address of Facility	8/2007 R SOL LEVINS	oc.Location - City or Town, State REISTERSTOWN, MD SON & BROS., INC. PIKESVILLE, MD 21208
Py60, sate be executed hysician and physician and the buriar-transit the buriar-transit the primary and the pr	lical Examiner	23a. Part1. Enter the disease, or complications that used the death. Do not each shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C	CANCE	ER	st, Approximate Interval Between Ossat and Death
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n Or ng Phys After this	Certification: To Be	25. Was case referred to medical examiner? 1	of y M 1 Yes 2 No	28d. Describe how	nce 6 Sther (Specify) DOVE I winjury occurred
the Hospita nin 24 hours the Funeral	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, do 2 Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place investigation, in my opinion, death occurred 29c. License number	urred at the time, da	ate and place, and due to the cause(s) Od. Date signed (Month, Day, Year)
To with	-	30. Name and address of person who completed cause of death (Item 23a) (Type	D35398	1	1-16-07
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Herbert Lemon		State of Maryland /	/ Department of Health and Mental Hygiene Certificate of Death Rep. No. 2007 37	1038
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. rant: If item 27 is marked other than 'v		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
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of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be After this certificate has been signed by the attending physici funeral director, page 2 should be detached for use as the buri		IF FEMALE: 23c. If yes, outcom 23b. Was decedent pregnant in the	Device a Company of the Company of t	Vaar
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Hosp 24 hc Fun etely	a	29a. Certifier 1 Certifying Physician: To the best of my	ny knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of exam and manner stated.	amination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
FSFS	ž	29b. Signature and file of certifier	29c. License number 29d. Date signed (Month, Day, Year))
5		/ / //	O.C.M.E. November 17, 2007	
7		30. Name and address of serson who completed cause of de	death (Item 23a)	
OCME	d	Mary G. Ripple MD. Deputy Chief Medic		1
Sta	ate		ar's Signature	-
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Examine	∍r	4a. Facility Name (If not institution HOSPICE OF BALT			CTR.	4b. City, Town		SON		4c. Count	ty of Death RAI	TIMORE
Funeral Director		5. Social Security Number 215-16-0802	6. Sex 1 M 2 □ F	7. Age (In yrs.		If Under 1 Ye Months Da	ar If Unde	r 24 Hrs. Min.	8. Date of Birth (Month, Day) 04/24/	Yea <i>r)</i> 1921	9. Birth	place (State or Foreign intry)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	l Director	Usual Residence of Decedent	TIMORE		ty, Town or Lo	RE 10f. Zip Cod	e 21244		1	0g. Citizen of		10d, Inside City Limits 1 □ Yes 2 No
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hysician this certifi al director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Accident	Hospital: 1 = 28a. Date (Mo	Inpatient 2 E e of Injury nth, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. [Other	Nursing Hor	n (Check only on me 5 ☐ Resid 28d. Describe h	ence 6	ther <i>(Sp</i> ec	ity) HOSPICE
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the Hospit in 24 hour the Funera	edical		ng Physician: To the Examiner: On the and ma			nvestigation, in r	ny opinion, d	eath occurr				
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В	}	30. Name and address of person	who completed as:	lea of death (the	m 23a) /Tuna	Print)	6439	10	/	NOVEME	3ER 10	0,2001
1		DANIEUL DOBERA	WAN, MD	2505 N	CHARLE	S STAGE	T. 811	TE 20	9 BAL	TIMORE	- mo	21204
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DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

> State Registrar

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NOV 2 0 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type,

and manner stated.

ORIGINAL

29c. License number

D2S663

212A

29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

NOV 2

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A

augarajan

32. Reginar's Signature

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in 99 the funeral director, page 2 should be detached for use as the burial - transit completely filled in 99 the funeral director, page 2 should be detached for use as the burial - transit Box 68760, Division of Vital Records, P.O.

Physician/Medical UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? ✓ Yes 2 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 DOA Inpatient 2 No 1 ✓ Yes 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred Certification Motorcycle driver collision with auto 1 Natural FOUND: Yes 2 V No Pending Nov 11, 2007 0000 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Rt 4 and Brickhouse Road, Owings, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

She selfe

Margarita Korell MD.

31. Date filed (Month, Day, Year,

O.C.M.E. November 12, 2007 111 Penn Street, Baltimore, MD 21201 DONEL!

9

State

Registra

23d. Date of delivery

death?

1 V Yes

Month

Day

24b. Were autopsy findings available

prior to completion of cause of

2 No

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37044 Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 0220 AM ESTHER B MYER NOVEMBER 2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 1 □ M 2 🔀 F Months Days Hours 213-18-0413 85 July 29,1922 MAryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland N/A Baltimore 1 XYes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 356 Folcroft Street 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【No Specify: Specify: White 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 years Press Operator Can Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leo. M. Patterson Anna Shane 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Kowalewski grandbaughter 2811 12th Street, Millers Island, Maryland 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 1 ☐ Burial 2 ☐ Removal from State Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 20, 2007 Baltimore City, MD. ig ature of Foneral Service Licen e Connelly Funeral Home Of Dundalk, P.A. nthone 7110 Sollers Point Road, Dundalk, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE DAY Due to (or as a consequence of): PNEUMONIA 4 DAYS Sequentially list conditions, Due to for as a gunariquing of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform rmed 2 Mo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death Check onl one examiner'

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show a or 28a-f sh t be notified

ms 23a

'natural', or Items dical Examiner mu

Director

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Completed

Be

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the Maryland

death with

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If then 27 is marked other the any injury or other trainments.

The law requires that the death certificate be executed

Box 68760.

P.O.

Division or Vital Records,

Hospital or Attending Physician;

the

þ Completed Be P

Physician/Medical Examiner burial-trar physician the as use for director, funeral Certification:

27. Manner of Death 1 Natural

ed by the a cate has been signed page 2 should be det After within 24 hours after death To the Funeral Director; p filled in

O

State Registrar

completely

29b. Signature and title of certifier

2No

1 ☐ Yes

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hand

5 ☐ Pending investigation

6 Could not be determined

RES-000

1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

29c, License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 TYes 2 TNo

29d. Date signed (Month, Day, Year)

NOVEMBER 17, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ELIZABETH HARRIS M.D. 31. Date filed (Month. Day. Year)

NOV 2 0 2007

4940 EASTERN AVENUE 32 Registrar's Signature

28a. Date of Injury (Month, Day Year)

BALTIMORE, MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 19a per fin 9873 11-27-07 yt.
State of Merylands Department of Health and Mental Hygiene

Amend 326 Per Phy G873 12-27 lineate of Death

Reg. No. 2 0 0 7 Reg. No 2 0 0 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 13, 2007 3:50 A M Anthonv Louis Makar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll 4215 Navajo Drive Westminster 8. Date of Birth (Month, Day, Year)
Apr. 18, 1 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1X M 2□F Min. 215-30-5262 73 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Lady Lake FLLake Director 10f. Zip Code 32159 10e. Street and Number 801 Trevino Drive 10g. Citizen of What Country? United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify:White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Warehouse Supervisor Tire Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Makar Elizabeth Eringis မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Dorothy Makar-Daughter 801 Trevino Drive, Lady Lake, FL 32159 20b. Place of Disposition (Name of cemetery crematery of other place)
West Arundel Date 20c. Location - City or Town, State Method of Disposition Burial 2X1Cremation 3 Removal from State 4∏Docation 5 ☐ Other (Specify) 11-16-2007 Odenton, MD Crematory 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 3a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) CANCER **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: 1 ☐ Inpatient Daughter's Other: 4 Nursing Home Statesidence 6 XX ther (Specify) P 1 TYes 2 ER/Outpatient 3 DOA this Residence completely filled in by the funeral after death. 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 2 ☐ Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in any anisis. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number 16354 NOVEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE BALTIMORE MD 21229 ST AGNES 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 19, 2007 Charles Metcalf, Jr. 2:34 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore Gilcrest Hospice Towson 6. Sex 1 M M 2 ☐ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours 87 212-14-2306 Feb. 11, 1920 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State or items 23a or 28a-f show aminer must be notified at 1 ☐ Yes 2 XNo Directo Baltimore Arbutus 10g. Citizen of What Country? 10e. Street and Number 1148 Elm Road 10f. Zip Code 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No1942 = If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White X Widowed 4 Divorced 1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Westinghouse and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles A. Metcalf Gladys E. Kaler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is in any injury or other traun 2925 Barret's Pointe Rd., Williamsburg, VA 23185 Patricia Ecton - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 11-24-2007 Baltimroe, MD □Donation 5 □ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. any ir 1328 Sulpur Spring Rd., Arbutus, MD 21227 Part1. Enter the disease, or complications that couled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STROKE DAYS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DRONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC RENAL DISEASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 2000 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To ō 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 ☐ Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) D64395 NOVEMBER 19,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHARLES ST, SUITE 209 BALTIMONE, MD 21204 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For Amend #5 Per FH 0873 11/27/07 JH Cartificate of Death

Cartificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** NOV 2001 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LENTER FOR HOSPICE CARE BALTIMORE TOW50 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F Director do Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 27s and any injury or other traumatic contracts. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 □ No Director 10g. Cirizen of What Country? 10e. Street and Number 10f. Zip Code by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) + HGRADE GETHLEHEM STEEL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TEORGE NNIEပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERNESTINE ALTO, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) JR. FUNERAL HOME 21. Signature of Funeral Service Licenses 22. Name and Address of 148 ULTON AVE. BALTO, MD 212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ours /Medical to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Tyes 2 TNo been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by costnte 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 2 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ neral Director: After this filled in by the funeral di 27. Manner of Death 28a Date of Injury 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 Hatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier N. Charles St. Balts Md Z1205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 me 32. Pojistrar's Signature 31. Date filed (Month NOV2 0 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 18, 2007 3:25 pm November Mae Belle McDonald /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Ivy Hall Geriatric Center Middle River If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🛛 F Days Hours Director 90 7/5/1917 215-16-9403 Virginia Usual Residence of Decedent death with the Maryland 10c, City, Town or Location 10d Inside City Limits 10a State 10h Counts ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ∐Yes 2X No Director Middle River Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2134 Riverthorn Road 21220 S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No þ Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be marked Susie F. Costello Henry A. Rutherford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard McDonald - Son 2134 Redthorn Road Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Holly Hill Mem. Gard, 11/24/2007 Middle River, Maryland 21. Signaure of Funeral Service Ligensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strick, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DISGASE **Physician** /Medical PERTENSION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner MABETES requires that the death certificate be executed MELLI physician and s the burial-trans Physician/Medical attending p for use as 1 IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 XNo 2 No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No မ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29c. License number 29b. Signature and title of certifier 0 LL MD D27188 11-19-07

death (Item 23a) (Type, Print)

LL ZMaxley Pkac Dunda(KN) 2122

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 200 James J Maginnis /Medical 4a. Eacility Name (If not institution, give street and number) 4b. City Town, or Location of Death of Death **Examiner** If Under 1 Year Birthplace (State or Foreign Country) Social Security Number Aue (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** (Month, Day, Year September 27 Days Months 1 M 2 □ F 201 10 4084 86 1921 Stuville, Ohio Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Muntal Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore County 'natural', or items 23a or 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1500 Draper Ct 21237 USA Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No Specify: Specify: þ 3 Widowed 4 ☐ Divorced White Completed permit. Pages 1 and 2 should be filed within 72 hr. Decartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Supervisor Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Wellington Maginnis Elizabeth Vaughn Richardson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Lee Maginnis 29462 West Ridge Road Princess Anne, Md. 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gardens of Faith Cem. November 24 2007 Baltimore, Maryland 21. Jonatus of Funeral Service Licenses 22. Name and Address of Facility Lassahn Funeral Home Inc 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 days Physician disease or condition resulting in death) ntracerebra /Medical Due to (or as a consequence of): Examiner Netastasis cequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Dronchogenia Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Partl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform oronaru isease 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 XNatural 5 ☐ Pending investigation Notice with the within 24 hours after dearn.

To the Funeral Director: After the function of t 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mya 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37050 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, Month 950 Nuh **Physician** Treven Miller /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 8820 Walther Blvd., Apt. 3512 Parkville If Under 24 Hrs Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1□M 2XF Months Maryland Yrs August 19,1924 83 Director 220-14-8154 Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.

other then "netural", or Items 23a or 28e-f ehow 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other then "netural", or Items 23a or 28e-f ehow traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No Directo Parkville Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21234 Apt 3512 8820 Walther Blvd.. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Completed by 3

Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Rigging Company Treasurer 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 end 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be E. McCaulev Helen Charles Haynes ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maryland 21222 101 Kinship Road Baltimore, Joyce Miller Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov.23. 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Redeemer Cemetery 2007 Baltimore, Maryland 4 Donation 5 Other (Specify) e of Funeral Service Licensee 22. Name and Address of Facility Ruck TowsonFuneral Home, Inc. Towson, Maryland 21204 1050 York Road an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner sate has been signed by the ettending physician end page 2 should be detached for use as the bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Onknown ð 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Tes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Attel within 24 hours efter ded To the Funerel Director completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c.\License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilthen Blud

8800

32 egistrar's Signature

Registrar

DAMCE

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Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month lovember. 15,200 V. Morris Doris 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Maryland General saltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01 03 23 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 M 2 F 84 218-18-7437 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√ Yes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3901 Cranston Ave 21229 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Yes 🎇 No Specify Specify: Black 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Luggage Manufacturer Balto. Luggage na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William D. Bush <u>Clara Green</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Scott-Daughter Cranston Ave, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore National 11/21/07 Baltimore, Md 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21. Sign tun of Funeral Service Licente 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart vailure. List only on cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Quato (or as a consequence of) oni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 npatient

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show adical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must once.

Baltimore, Maryland

Director

Funeral

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Completed

Be ဂ္

with the Maryland

and the attending physician

Examiner

Physician/Medical þ Completed Be Certification: To

ca

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this

Division or Vital Records, P.O. Box 68760,

State

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

NOV2 0

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

28a. Date of Injury (Month, Day Year)

and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Naeem 32. Redistrar's Signature 31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

3 DOA

28c. Injury at Work?

Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician ^{Day}7 2007 S. Mrozinski John November 6:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 731 S. Montford Ave. Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**x** M 2□ F 71 220-30-6951 Director August 9, 1936 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at N/A 1 Wes 2 No Director Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or ? must be r 731 S. Montford Ave. 21224 USA Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian the Medical Examiner 1 Never Married Married 1√ Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify White Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I die...
I Health and Men...
I item 27 is marked of John J. Mrozinski Jennie Nan Tomaszewski ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. Mrs. Mary Jane Mrozinski/ Wife 731 S. Montford Ave. Baltimore, Md. 21224 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 11-21-07 Towson, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 1 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed? Yes 2 No certificate or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 NO 1 🗌 Yes Certification: To 5 Residence 6 □Other (Specify) this 27. Mann of Death sompletely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the transmission of the properties of the prope 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated, 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Donald attanasio MD-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sute 108 Baltanore Red - 21237 9114 Philadelphia 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Maryland 21215-0036

Baltimore,

Division or Vital Records,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11/13/2007 Year 8:00 P M Michael T. McGinn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 12147 Dove Circle Laure1 Prince George's If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Months Hours 1X M 2 F 10/30/1948 59 215 54 9134 Washington DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 TXYes 2 □ No Director MD Laurel Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or adical Examiner must be n 12147 Dove Circle 20708 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 196 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. White 1 Kyes 2 No 1968-If Yes, Give Year or Dates: 1970 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "n any injury or other traumatic event, the Media once. Elementary/Secondary (0-12) College (1-4or 5+) Printer Printing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William John McGinn Elsie Degner 19a. Informant's Name/Relationship (Type. Print)
Ellen Womersley/ Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2722 Dartmouth Dr., Janesville, WI 53548 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery //-/7-07 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3401 Bladenburg Rd., Brentwood, MD 20722 Approximate Interval Between Onset and Death I yr Immediate Cause (Final disease or condition resulting in death) Metastatic Adeno Carcinoma of the Colon **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine be executed Due to (or as a consequence of) attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical that the death certificate IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown been sig 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy certificate 1□ Yes 2 XNo Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 Tyes 2 □ No 2 Accident the Funeral Director: npletely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after Medical 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 00058213 arhace 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Farhad Jamali, 7305 Hanover Pkwy, Greenbelt, MD 20770 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

obert Edwin M		n State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2007	3705
Physici ledical Exam	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	ne of Death 932 hrs
)	11161	Robert Edwin Mason November 12, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
		3709 Saint Margaret Street Baltimore 5 Social Security Number - 1- 6 Sex	(0)
Funeral Director		1 X M 2 F 64 Yrs. Months Days Hours Min. Feb 5, 1943 Foreign Country)	New York
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d.	Inside City Limits
faryland 28a-f show I at once	ctor	TID BATTERIOTC A	Yes 2 No
eath with the Maryland items 23a or 28a-f sho ust be notified at once	Dire		
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. ten 77 is marked other than "natural", or items 23a or 28a-f shi reammatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 1 N	
rs after ural",	by	3 Widowed 4 Divorced of Yes, Give Year or Dates. 1 Yes 2 X No specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industrial Control of Specify: White 15 Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industrial Control of Specify: White 15 Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industrial Control of Specify: White 15 Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industrial Control of Specify: White 15 Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industrial Control of Specify: White 15 Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industrial Control of Specify: White 15 Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industrial Control of Specify: White 15 Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industrial Control of Specify: White 15 Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industrial Control of Specify: White 15 Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industrial Control of Specify: White 15 Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industrial Control of Specify: White 15 Decedent's Usual Decedent's Usual Decedent (Give kind of work done 16b. Kind of Business)	
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21215-0036 nuld be filed within 7 Mental Hygiene. marked other than c event, the Medi-a	Be Co		unk
212 ould be d Ment s mark	To B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C	Code)
MD nd 2 sho alth and m 27 is		JoAnn Walker/daughter 1707 Fairleigh Court Leesburg, VA 20176 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town,	State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other tranmantic event, the Medical.		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 X Other, Specify: ix7 State	
Balti permit. Departr Import		22. Name and Address of Facility Renald State Anatomy Board 655 W. Baltimore Sta	reet
Physician			oroximate Interval
/Medical		Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease	Death
		or condition resulting in death) Due to (or as a consequence of):	
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
=	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):	
68760, cer fificate be executed nding physician and se +s the burial - transit			
60, ate be ex hysician e burial	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Box 6876 death cer (ficate the attending physel for use as the	cian/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
30x death of a atten	hysic	1 Yes 2 No 9 Unknown g Unknown	
3. 4 ≥ 5.	by Ph		
ords, P.C w requires that as been signed? should be deta			
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tal Rection: The certificate ector, page	ပြ	1 Yes 2 ✓ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one)	2 No
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	-	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred	
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Division pital or Attendi ours after death. eral Director: /	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)	oute Number, City
Div To the Hospital of within 24 hours at To the Funeral E	Medical C	29a Certifier	se(s)
To To	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, D	ay, Year)
		Carol Halan O.C.M.E. November 13, 2007	
		30. Name and address of person who completed cause of death (Item 23a) Carpl Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimpre, MD 21201	
	tate	RILLY 9 0 2007 1800 1800 1800 1800 1800 1800 1800 1	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Victoria Mock Nevember 15 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner West 40th Street Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🗙 F Hours Min. 250-64-4203 Director July 29, 1942 Maryland Usual Residence of Decedent r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

The marked other than "natural", or items 23a or marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Street 2121 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White ≥ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Johns Hopkins University Elementary/Secondary (0-12) College (1-4or 5+) in Chair School of Nursine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Geneva Fleming James Meck ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40th Street Baltmore, MD 2/2/1 Quentin McKennis / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry November 15, 2007 4 Donation 5 ☐ Other (Specify) Hanover MD 21. Signature of Funeral Service licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Drive Suite P. Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 70~77 Metastatic MELGINOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and/ Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 → 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P within 24 hours after death. To the Funeral Director; After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 28b. Time of Certification: To the Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

13113

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11/15/07

Ra # 415 Whall Md 21093

MD

10753

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Concept Age Control				1 - For State Registrar	State of	f Maryland / Dep <i>Ce</i>	artment of I		d Mental Hy	giene Reg. No.	007	37057
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			State of Maryland / Department of Health and Men 1 - For State Registrar Certificate of Death		2007	37058
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Georse J. McWILLIAMS No	Date of Death Month D	eay Year 2007 Ic. County of Death	3. Time of Death 6:45a
	Funeral Director	eı	Franklin Woods Nursing Home White Marsh 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. If Worth Park Min. Mi	Date of Birth (Month, Day, Yea -13-193	r) Cou	place (State or Foreign ntry)
-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or items 23e or 28a-f show important: If item 27 is marked other then "netural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examinant ust to indiffed at once.	ted by Funeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2X No Specify: Year or Dates:	/ Yes or No- an, etc.)	USA 14. Race - Amen Black, White, Specify: White	can Indian, etc. Lte
Maryland 21215-0036	be filed within 7: ntal Hygiene. ed other then "n event, the Medi	Be Completed	o 17. Father's Name (First, Middle, Last) 18. Mother's Name (Fill and American State of Stat	irst, Middle, Maid		Can Co.
Baltimore, Maryla	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 Is marks any injury or other traumatic once.	То	19a. Informant's Name/Relationship (Type, Print) Lucille McWilliams – Wife 20a. Method of Disposition 1X Buriai 2 Cremation 3 Removal from State 19b. Mailing Address (Street and Number or Rural Rolling Address) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date	oute Number, City nore, M 20c07	y or Town, State, Zi D 21224 Location - City or T Baltimon i Funera	own, State Se, MD al Home, PA
760,	the burial-transit	iical Examiner	d	E	-	Approximate Interval Between Onset and Death
.O. Box 68	death certific e attending p ed for use as i	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Yes 0 1 Yes 2 Yes 0 1 Yes 2 Yes		23d. Date of deliver Month	very Day Year
s, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant containors continuous contin	1 🗆 Yes	2 No 3 Pro	
Vital Record	The ate h page	e Completed	0	24a. Was an autopsy performed; 1 Yes 2 K	prior to c death?	opsy findings available ompletion of cause of
Division of Vi	ng Phys (fer this	Certification; To B	examiner? O 1 Yes 2 No	5 Residence	njury occurred and Number or Ru	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and eath occurred a and manner stated.	at the time, date	e(s) and manner as and place, and due Date signed (Month	to the cause(s)
)	To with	W	1 Jim Parshall D40008		11/12/	07
	Sta Registr		TIMPARSHALL 9105 FRANKLIN SQUARE 18 18 31. Date filed (Month Day, Year) 2007 32. Registrar's Signature	DR., B.	ALTIMO	RE, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6:00 P.M NOVEMBER 2007 RUTH A. MESSHAM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE 1668 THETFORD ROAD PARKVILLE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 9/4/1922 5. Social Security Number 7. Age (In vrs. last birthday) Days Min. Months 1 □ M 2X F 85 CANADA 212-76-5228 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No PARKVILLE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number CANADA 21286 1668 THETFORD ROAD 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify: WHIE 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DOROTHY CONACHER JOHN N. HENDERSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) VIRGINIA FLETCHER/DAUGHTER 1668 THETFORD ROAD BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 11/19/2007 CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 21286 8521 LOCH RAVEN BLVD. TOWSON, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Anset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to infractions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Period hered Due to (or as a consequence of):

Physician /Medical Examiner Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral Director

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Be Completed

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MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

24 hours after death Funeral Director: filled in by

þ

Be Completed

Medical Certification: To

29b. Signature

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▶ No 9 □ Unknown	23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3□Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions Ltypelic.		sulting in the underlying	cause given in Part I.	23e. Did tobacc 1 ☐ Yes	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
				24a. Was an autopsy performed 1∐ Yes 2	
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1	Hospital: 1 ☐ Inpatient 2 [☐ER/Outpatient 3☐ □	OOA Other: 4 Nursing	Home 5 Residence	e 6 □Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred
3 ☐ Suicide 6 ☐ Could not determine		nome, farm, street, factorify)	ory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, tate)
	Physician: To the best of my kr amlner: On the basis of examin				e(s) and manner as stated. and place, and due to the cause(s)

29c. License number

D-53802

29d. Date signed (Month, Day, Year)
Worknber 19, 2007

State Registrar

mo 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2 0

1447 York Road Lutherville, MD

mp person who completed ceuse of death (Item 23a) (Type, Print)

within 2 To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Packer Baldina Cranesis Yack ville If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 4/17/1934 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday **Funeral** Days 1 □ M 2 🔀 F Hours 215-30-4366 73 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MDBaltimore Parkville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1801 Wentworth Rd Funeral 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled win Department of Health and Mental Hygien Important: If Item 27 is marked other than any injury or other trainmasts. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter LeFevre Alberta George 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gilbert Monaghan-Son 1534 Sharen Dr Apt F Salisbury,MD 21804 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 11/19/07 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 6415 Belair Rd Baltimore, MD 21206 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCUD Wars /Medical Due to (or as a consequence of): Examiner Victoretes VCALI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 aftending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1∐ Yes 2 **X** No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) မ 1 🗀 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number

State

29b. Signature and title of certifier

31. Date filed Month, Day,

Kleere

NOV 2 0 2007

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001 Chocks

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TOWSE

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29d. Date signed (Month, Day, Year)

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21204

			State of Maryland / Depart	ment of Health and M	lental Hygien	e
		•	1 - For State Registrar Certi	ficate of Death	Reg. No	10000 0000
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia		Marjorie Pearl Noone		Month Da	2007 2 58 P M
	/Medic		4a. Facility Name (If not institution, give street and number) 4	b. City, Town, or Location of Death		c. County of Death
	Examin	er	FRANKLIN SQUERE HOSPITAL CENTER	Rosedale		Baltimore
	Funeral		5 Social Security Number 6. Sex 7. Age (In yrs. last birthday)	f Under 1 Year If Under 24 Hrs.	8 Date of Birth	Birthplace (State or Foreign
	Funeral Director		180-22-0553 1□ M 2\\$F 80 Yrs.	Months Days Hours Min.	(Month, Day, Year 06/30/192	
			Usual Residence of Decedent		. 34,34,136	
	ylanc iow		10a. State 10b. County 10c. City, Town or Locat			10d. Inside City Limits
	Mar fied	햦	Maryland Baltimore Middle Ri	ver		1 ☐ Yes 2 🔀 No
	r 28; noti	irec	10e. Street and Number	10f. Zip Code	"	itizen of What Country?
	h wit 3a o st be	<u>ام</u>	2114 Graythorn Road	21220	U.:	S.A.
	after death with the Maryland or items 23a or 28a-f show miner must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Armed Forces?	s Decedent of Hispanic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
0	after or ite		1 Never Married 202 Married 1 Nes 257 No	es, specify Cuban, Mexican, Fuerto	, 5.0.,	
S	ral", c	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	3.00 ZZ110 Opoony.		Specify: White
2-003p	72 hours natural", dical Exa	etec	15. Decedent's Education 16a. Deceder (Specify only highest grade completed) (Give kin	nt's Usual Occupation ad of work done during most of work NOT use retired)		Kind of Business/Industry
7	thin an "l Med	nple	Elementary/Secondary (0-12) College (1-4or 5+)			
7	e filed within al Hygiene. I other than ' vent, the Me	Completed	12 Atten			ransportation
9	be filk	Be (17. Father's Name (First, Middle, Last)		e (First, Middle, Maide eifert	en ourname)
/lan	ould t Ment arkec	To	Arthur Walter			
a	12 should be finance of the first marked of traumatic even		2114 0	Address (Street and Number or Rui	al Route Number, City	or Town, State, Zip Code) R Maryland 21220
_	1 and 2 Health tem 27 i					r, Maryland 21220
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, crema	ion (Name of tory or other place)		Location - City or Town, State
Ĕ	Pag nent int: It		4 Donation 5 Other (Specify) Bayview Cr	ematory Ind 1/2	0/200 Bal	timore, Maryland
a	permit. Departr Importa any inju					Funeral Home P.A.
ñ	an)		John W. Burkauske 14	07 Old Eastern A	venue, Ess	ex, Maryland 21221
			23a Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final	nsis		Onset and Death
)	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	-1' -1-	-	
	Examiner		Minany tra	ct in fection	J	
	تناسلة	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	0		
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
J.	exec in an		resulting in death) Last Due to (or as a consequence of):			
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٥	g phys as the	ledi				
X Q Q	leath certifica attending ph for use as th	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ E	ctopic pregnancy		23d. Date of delivery
ň	death a atte	icia	in the past 12 months? 1 Ves 2 Velo	Other (specify)		Month Day Year
o.	t the	hys	9 ☐ Unknown			
ī.	w requires that the di been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the und		23e. Did tobacco	o use contribute to the cause of death?
D S	quires n sigr ıld be	d by	Atrial Fibrill atron with rapid V	entricular respons	e 1□Yes	2 No 3 Probably 4 Unknown
Ö	w rec beer shou	lete	acute renal failure	•	24a. Was an	24b. Were autopsy findings available
T T	or Attending Physician: The law requires that the death certific after death. Director: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as	Completed			autopsy performed?	prior to completion of cause of death?
Vital Records,			25. Was case referred to medical	26 Place of Dog	1 Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	No 1 ☐ Yes 2 ☐ No
	sicia certi recto	Be C	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other	ome 5 ☐ Residence	6 □Other (Specify)
Ö	Phy: r this ral di	은 -	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at Work?	28d. Describe how inj	
S C	ding h. Afte. fune	tion	1 Natural 5 Pending (Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		
DIVISION OF	Attend death. cctor: /	Certification:	3 Suicide 6 Could not be 28e. Place of injury - At home, farm, stree	et, factory, office	28f. Location (Street	and Number or Rural Route Number,
2	after after Direct	ertii	4 Homicide determined building, etc. (Specify)		City or Town, Sta	are)
	spita ours reral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of	occurred at the time, date and place	, and due to the cause	(s) and manner as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invegand manner stated.	estigation, in my opinion, death occu	rred at the time, date a	and place, and due to the cause(s)
	o the	Me	29b. Signetyre and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
	F S F Ö			ROSDADO	20 11	119/2007
	Y		30. Name and address of person who completed cause of death (Item 23a) (Type, Pi	rint)	-0 11	1. 100
10			30. Name and address of person who completed cause of death (item 23a) (1996, Pi	Res 0000	Baltimore	mp 2/237
ď	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	The Control of the Co		
	Regist		4040 0 0007 Page 18 A	ast)		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 37062 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** UCILLE Year NELSON 81.00 AM November 13,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL NIA UNION MEMORIAL BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 M F 212-20-2817 Director MARCH 15,1926 NORTH CAROLINA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10h Count 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at BALTIMORE 1 ¥Yes 2 No Director MARYLAND 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 3815 BEEHLER AVENUE U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by 3 Widowed 4 ☐ Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CHURCH permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any InJury or other trainment. 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Surname) ROGERS ADDIE DAVID ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PRISCILLA BROOKS (DANCHTER) 6 APPLE GATE COURT, PIKESVILLE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State KING MEMORIAL PARK 11-19-2007 4 Donation 5 Dother (Specify) BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 30 SEPH H. BROWN JR. FUNERAL HOME SUM N. FULTON AVE, BALTIMOREMD 21217 Illiamo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY artery disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical as If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 4☐Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No Month Day Year 5 ☐ Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ② Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 24a, Was an certificate 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide thin 24 hours a Example 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Od, sendas November 13, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21219 DANN W KERSHNER 54 Shite Sox 3333 N Calvert 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend 38,10e&f Per FH G873 11/20/07 JH of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 1: 23 PM Physician 13 OPPITZ 2007 NHOL /Medical 22 S Greene Stb. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner City Baltimore City Browner, M. 211 21 (State or Foreign of In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 2-16-1928 irrhplace (State or Foreign Month, Day, Year) | Ballumore, Maryland TRAUM COURTE, L of Manylows 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Baitimore, Maryland 1 XM 2 □ F 217 26 2977 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 XNo NOTINGHAM MD Baltimore Director 10f. Zip Code 21236 10g. Citizen of What Country? 10e. Street and Number 3724 East Joppa Road LESA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 X Never Married 2 Married 1 ☐ Yes 2 K No WHITE Specify Specify: Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced 'natural", 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) and Mental Hygiene. Clothing Industry Tailor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Sauer John Francis Oppitz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8020 Belair Road Suite 200 Baltimore, Maryland 21236 George A Rhoads (nephew) item 27 l 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of F Important: If ite any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc November 14 2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sonatur of Funeral Service Licensee 22. Name and Address of Facility
Lassahn Funeral Home Inc 102thas 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death APRIOTE BY MEDICAL EN Immediate Cause (Final BRAIN IN JURY Physician TRAMMATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SPINA Cons squardially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Lune ann CERTIFIC Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 Tyes 2 No. 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by with Intransmini 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Dully Leurs / Prismo Throng fx, Brathel 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Fx, 6 Ft From autopsy performed? Yes 2 No EV, 6.45 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation STRUCK 1 ☐ Natural Pederrein 1 ☐ Yes 2 ☐ No 12/07 2 Accident LUKKHOWA Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide BARRAUTE Country 3200 block of East Juppa within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 18234 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3

DHMH 17 Rev 1/2001

State Registrar Bennett

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

/Medical Examiner certificate be executed Box 68760, P.0 Records, or Vital the Hospital or Attending Physician: Division

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To the Funeral Director: After this of state of the funeral director.

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other than "natural", or Items 23a or 28a-f shovent, the Medical Examiner must be notified at

death v

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permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marker any Injury or extra

Physician

Baltimore, Maryland 21215-0036

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 27. Manny of Death 1 Matural 2 ☐ Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar

31. Date filed (Month, Day,

00 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			State of	Maryland / [lental Hy	giene		
		1	State Registrar		Certi	ificate of L	Death		Reg. No.	107	37065
	Physicia		Decedent's Name (First, Middle, Last)	D1				2. Date of Dea Month Nov 15,	2007	Year	4:00 P M
	/Medic	al ⊱	Roy B	Plotts		4h Oib Tour		MOV 13,		nty of Death	4:00 F W
	Examin	er	4a. Facility Name (If not institution, give street and num.	ber)		+b. City, Town, or	Largo				orge's
- X	Funeral		Manor Care Nursing Home 5. Social Security Number 6. Sex	7. Age (In yrs. last bit		If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birthp	lace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F XX	86	Yrs.	Months Days	Hours Min.	(Month, Day Aug 13		Mary	
	pr ,		Usual Residence of Decedent	10c. City, Tow	n or Loca	tion				1	0d, Inside City Limits
	anylar show	5	10a. State 10b. County								1 □Yes 2□No
	the M 28a-f notifie	Director	Maryland Prince George's	Upper	Marl	boro 10f. Zip Code			10g. Citizen	of What Cour	
	Mith Sa or t be r		12900 Brookelane			2007	72		Unit	ed Sta	tes
	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show sht, the Medical Examiner must be notified at	Funeral		dent Ever in U.S.	13. Wa		spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No		Race - Americ	an Indian,
9	after or ite		1 Never Married 2 Married 1 Yes If Yes, Give		i	Tes, specify ouble ⊒Yes 2√√2 No	Specify:	or tiouri, etc.,			ite
215-0036	ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Da	ites:						f Business/In	
7	ייר א 27 ר "natu edica	lete	15. Decedent's Education (Specify only highest grade completed)		(Give ki	nt's Usual Occup ind of work done o D NOT use retired	turing most of work	king	100. Killu u	i business/iri	uusiiy
212	withir iene. than the Mi	Completed	Elementary/Secondary (0-12) College (1-	-4or 5+)]	Farm				Agri	cu1tur	·e
9	should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 5a or 28a-f show imatic event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	•		name)	
<u>ä</u>	should be tand Mental something some	To E	Wallace P	lotts				May Bi			
Maryland	2 sho and I is ma		19a. Informant's Name/Relationship (Type. Print)		•	•	and Number or Ru				
	es 1 and 2 should b of Health and Ment item 27 is marked r other traumatic e	1	Clara V. Plotts (WIFE)				Lane, Ur			on - City or To	
5	Pages 1 nent of H int: If Ite iry or ot		20a. Method of Disposition 1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	State cemete			e) Nov 19,			ınd, MI	
Baltimore,	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (Specify) 21. Signature of Fune al Service Lens	wasni			al Cemete ss of Facility Lee	3			
Ba	Department once		VILLOUS IN	00153	10.		Ferry Ro				735
ŗ.			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	aused the death. Do							Approximate Interval Between
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	/Medical			or as a consequence							·
	Examiner	L	Seruentially list conditions,	anced Blad		Cancer				-	
J	ed sit	Examiner	cause. Enter Underlying	or as a consequence		Digongo					
* 	xecut and al-trar	xan	that initiated events cCI	onary Art or as a consequence		DISEASE					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	lical	d. Acut	te Orchron	nic r	enal Fai	lure				
9	rtificat ng phy as th		JE EEMALE.								
Box	leath certifica attending ph	Physician/Mec		come pf pregnancy pirth 2 DFetal deat		Ectopic pregnancy	1		23d	Date of deliv	ery Day Year
	ie dea the at ned fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nant at time of death own	5	Other (specify) _					,
P.0	res that the de signed by the a be detached f		Part II. Other significant conditions contributing to de	eath but not resulting	in the und	derlying cause giv	en in Part I.	23e. Did	obacco use	contribute to	the cause of death?
ds,	uires t signe Id be	d by						10	Yes 2□N	lo 3□Pro	bably 4 XIXnknown
Ö	w requir been si should	lete						24a. Was	an 2	4b. Were aut	opsy findings available
Records,	The lav	Completed						auto perf	psy ormed? 2 XIX lo	prior to co death? 1 ☐ Yes	ompletion of cause of
Vital	iclan: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of Dea				Ж.
<u>_</u>	Physic this ce al direc	To E		Inpatient 2 ☐ ER/C			4 LA Nursing F	lome 5□Res			ify)
Ē	Attending Physician: The death. ector: After this certificate his y the funeral director, page	on:	I Minatulal 3 Felicing	of Injury 28b. th, Day Year)	. Time of Injury	28c. Inju		28d. Describe	how injury o	ccurred	
Sio	tend seath. tor: /	cati	2 Accident Investigation 3 Suicide 6 Could not be 28e Place	of injury - At home,	farm stre		Yes 2 □ No	28f. Location	Street and N	umber or Rui	al Route Number,
Division or	i ji fe o	Certification:	4 Homicide determined buildi	ing, etc. (Specify)	iaim, oue				wn, State)		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier XX Certifying Physician: To the	best of my knowled	ge, death	occurred at the ti	me, date and place	e, and due to the	cause(s) ar	d manner as	stated.
	he Ho n 24 h he Fu pletely	Medical	(Check only one) 2 Medical Examiner: On the b	asis of examination a ner stated.	and/or inv			uneu at the time			
	To ti withi To ti com	X	29b. Signature and title of certifier			29c. Licens				igned (Month	
	/) (The			D0062	116		Nov	16, 20	U/
	L		30. Name and address of person who completed caus				1 7	WD 00==			
) Ct	ate	Meklit Workneh, 7705 F 31. Date filed (Month, Day, Year) 32. F NOV 2 0 2007	Selle Poin legistrar's Signature	t Dr	ive Gre	enbelt,	MD 20770)		
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The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 attending use detached for the be page 2 s certificate

Baltimore, Maryland 21215-0036

and burial-tran physician as the funeral director. this After death.

Physician: Hospital or Attending To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

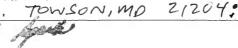
	7600	OSLE	12 1	21
State egistrar	31. Date filed	(Month Bay	2°0	6

29b. Signature and title of certifier

29a. Certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

00047625

29d. Date signed (Month, Day, Year)

RICHARD

O'MALLEY, MD

11/19/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav P^{M} November 9, 2007 2:45 Henry E. Phipps 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 € M 2 □ F 93 Dec 11, 1913 Maryland 213-10-8960 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No MD Baltimore Cockeysville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21030 300 International Circle USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: white 5 3 XWidowed 4 ☐ Divorced WWII Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) engineer mechanical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clinton Henry Phipps Emma Wolfkill ည 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Phipps/nephew Furnace Court Hunt Valley, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3 □Removai from State 1 ☐ Burial 2 ☐ Crematic 4 ☑Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Director Ronald State Anatomy Board 655 W. Baltimore Street un <u>Baltimore, MĎ</u> 23a. Part. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WARENAL ANOURYSMA KUNTUKOS ahrs Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed

Physician /Medical Examiner

attending physician

Physician

/Medical

Funeral

Director

ns 23a or 28a-f show must be notified at

or items

permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hyljene. Important: If Item 27 Is marked other than "natural", or teen any injury or other traumatic event, the Medical Examiner

DS HEALY Inmore, Maryland 2/215-0036

death with the Maryland

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Certification: To

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29a. Certifier

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

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_			_								24a. Was an autopsy performed? 1□ Yes 2□ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25	. Was case referred	to medical						26.	Place of Dea	th (C	heck only one)	
	examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1 Impatient 2 ☐ ER/Outpatient			3 🗆	DOA	Other: 4	☐ Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)		
27.	2 Accident	5 ☐ Pending investigation		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c	. Injury at Work? 1 ☐ Yes	2 □ No	28d	. Describe how injury	y occurred
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	•	28e. Place of injury - At h building, etc. (Speci	ome, farm, stree	t, fact	ory, o	ffice			Location (Street and City or Town, State)	d Number or Rural Route Number,

2 Accident	investigation	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	
(1)	/	l

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6569 NCharles STRITE FOI Balt MD 2/204 DANO 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

hours after death

within 24 hours a Hospital

State of Maryland / Department of Health and Mental Hygieneo For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician Bruce Richard Peterson** 12:48 p. M November 7, 2007 */Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De 4c. County of Death Examiner Westminster Carroll County General Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) December 31, 1937 5. Social Security Number . Şex 1**X** M 2 ☐ F 7. Age (In yrs. last birthday) 69 yrs 9. Birthplace (State or Foreign **Funeral** Yrs Maryland Olto -34 -1770 Usual Residence of Decedent Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any lipiny or other traumatic event, the Medical Examiner must be matter and prop. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐ Yes 2 No Mt. Airy Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 906 Roller Coaster Ct. U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 25 If Yes, Give Year or Dates: 1 Never Married 2 Married 25 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nde pendent Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian ပ္ Teter Sor Luknown Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
 Roller Coaster Ct. Mount Airy, Maryland 21771 19a. Informant's Name/Relationship (Type. Print) Mrs. Barbara Peterson Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/09/07 Sykesville, Maryland All County Cremation Services, Inc. 4 □ Donation 5 □ Other (Specify) of Funeral Service 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 MED571 Approximate Interval Between Onset and Death 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. mediate Cause (Final if mediate Cause (indisease or condition resulting in death) **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) signed by the a 1 Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 robably 4 □Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy perform To the Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only on 1 ☐ Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NOutpatient 3 DOA 1 ☐ Inpatient 2 funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural (Month, Day Year) 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature 4 who completed cause of death (Item 23a) (Type, Print) 0700 CHANTER YON? 31. Date filed (Month, Day, Year) Registrar's Signature 32. State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			F	State of M	aryland /		ent of H					_		
			1 - For State Registrar		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 20						$Z \cap A \cap A$	37070		
	Physici	an .	1. Decedent's Name (First, Middle,	Last)						Date of Deat Month	h Day	Year	3. Time of Death	_
14	/Medic		Tregory	Kice						11	14	200 t	1735 M	
	Examir	ier	4a. Facility Name (It not institution,	10	Malia	4b. 0	Balty Town, or	Location of D			4c. (Counfy of Death		
	Funeral		0 (1110 . 3500)		je (In yrs. last		nder 1 Year	If Under 24	Hrs. 8	Date of Birth	V\	9. Birth	place (State or Foreign	_
	Director		218-86-4387	1 X M 2□F	46	Yrs. Mon	ths Days	Hours	Min.	Month, Day,	196		intry) MD	
	land ow It		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Location							10d. Inside City Limits	
	Mary a-f she	ioi	MD		Ba	Itimo	re						1 Yes 2 □ No	
	or 28	Funeral Director	10e. Street and Number				Zip Code			1	0g. Citiz	en of What Cou	antry?	
	s 23a nust k	eral	1625 Druid		nue	140 111-15	2	121-				USF	-	_
<i>.</i> ~	fter de r item iner n	Fune	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Armed Forces? 1 Yes 2			ecedent of His specify Cubar	spanic Origin n, Mexican, F	1? (Specify Puerto Rica	Yes or No- an, etc.)	'	 Race - Amer Black, White 		
93	ours a ral', o Exam	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Ye	s 2 No	Specify:				Specify: B	lack	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed by	15. Decedent's (Specify only highest	Education grade completed)	10	6a. Decedent's l	f work done di	uring most o	f working		16b. Kin	d of Business/I	ndustry	
12	withir iene. than	duo	Elementary/Secondary (0-12)	College (1-4or s	5+)	life. PO NO	pove pove	r			11/	rehi	use	
	al Hygi other vent, t	To Be Co	17. Father's Name (First, Middle, L.	ast)	1			18. Mother's	Name (Fi	rst, Middle, I	Maiden S		7000	_
ylaı	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importants if Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Junior Kin	ie ,				te	<u>elm</u>	a t	to	mes		
Baltimore, Maryland			19a. Informant's Name/Relationshi	(Type, Print)		9b. Mailing Add	ress (Street a.	nd Number o	or Rural Ro	oute Number	City or	Town, State, Z	0100	
			20a. Method of Disposition	CIVIOTAE	20b. Place	of Disposition	Name of	L FTIII	Date	·/ Da	140 20c. Loc	cation - City or 1	Own, State	_
	Pages nent of I ant: If Ite ury or of		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Gre	etery, crematory	or other place) 	lial	Λ 7	120	ltimo	an MD	
alti	permit. Pag Department Important: I any Injury o		21. Signatur of Funer Service Li	censee M.		22.	nd Address	s (Facility	reep	e Fu	ser	al Se	-vices	
	205 20		Vaughn	C. Tree	ne	5151	Balt	O. Na	t1 Ψ	Ke, K	3at	to, Mi	21229	
1	ate be executed Wedical Examiner The burial-transit		23a. Pant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death		
			disease or condition resulting in death)	a	ven_ a consequence	tailure	Cir	rhos	15					
		Examiner	Sequentially list conditions by Hepa ITIS C											
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)											
√ 			that initiated events resulting in death) Last	ated events c									_	
3760,	te be e ysiciar re buri	cal		d										
P.O. Box 68	ertifica ing ph e as th	Medi	IF FEMALE:											_
ĝ	The law requires that the death certifica tee has been signed by the attending phage 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal dea	ath 3 □Ectop	ic pregnancy				2	3d. Date of deli	very Day Year	
o.		ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death	5 Other	r (specify)						,	
ري ح	s that ned b e deta	y Pt	Part II. Other significant condition	A.T.			ng cause give	n in Part I.		23e. Did tob	acco us	se contribute to	the cause of death?	
ord	w requires that s been signed b should be det	ted t	Bilroth I n	ish dwd,	nal s	rump	LEAR		_ [1 🗆 Ye	es 21 <u>1</u>	No 3□ Pro	bably 4 Unknown	J,
Sec.	e law i has be e 2 sh	Completed by							_	24a. Was a autops	V	prior to c	topsy findings available ompletion of cause of	
Vital Records,	siclan: The law s certificate has b lirector, page 2 s		05)								2 No	death? 1 ☐ Yes	2 □ No	
	ysicla is certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Toppatie	ent 2∏ER/	Outpatient 3	Otho	r·		heck only on 5 □ Reside		Other (Spec	ifel	_
Division or	Attending Physician: r death. ector: After this certifics by the funeral director, p	Ju: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ıry 28t	o. Time of Injury	28c. Injury Work			Describe ho			ny)	_
Sio	tendil leath. tor: A the fu	catic	2 ☐ Accident investiga	tion		M	1 □ Y	es 2 □ No						
<u> </u>	I or Al after d Direc in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street a building, etc. (Specify)								l Number or Ru	ral Route Number,		
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifying	Physician: To the best	of my knowled	lge, death occur	red at the tim	e, date and p	place, and	due to the ca	ause(s)	and manner as	stated.	_
	the Ho iin 24 the Fu	Medical	one)	xaminer: On the basis o and manner st	r examination	and/or investiga	ation, in my op	pinion, death	occurred a	at the time, d	ate and	place, and due	to the cause(s)	
	Nith Con	Σ	29b. Signature and title of certifier				29c. License			2	9d. Date	signed (Month	, Day, Year)	
•	~		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						(14/20	7 1	_			
	7		100 . 0 .		_	a) (Type, Print)	St. R	Itimo	20	MI				
	Sta		31. Date filed (Month, Day, Year)	32. Pogiętr	ar's Signature		· ,)<	1-110	- J-42		-			-
	Registr	ar	NOV20	2007	a St	board								

DHMH 17 Rev 1/2001

ORIGINAL

		ļ	1 - For Amend 317	&18 Per F	Maryland H C874 1	2/21 2/21	artment 107 III tilicate	of Ho	ealth ai <i>Death</i>	nd M	ental	Hyg R	iene _{eg. No.} 2 (07	37	07
	Physici	an.	Decedent's Name (First, Middle, Last)				2.					of Deat h	h Day	Year 3. Ti		ime of Death
E.	/Medic		Lillie) •		Roo			-	11		16	2007	5:3	0p. M
	Examir	er	4a. Facility Name (If not institution, o		,		4b. City, To						4c. Coun	ty of Death		
			Joseph Richey 5. Social Security Number 6		7. Age (In yrs. last	t hirthday)	If Under 1		imor		8. Date	of Birth		0 Riethn	lace /State	or Foreign
	Funeral Director		220-24-7867	1□ M 3€□ F	7.7	Yrs.		Days	Hours	Min.	(Mon	th, Day,	Year)	Coun	try) SC	s or Foreign
Ģ.	40-		Usual Residence of Decedent	1							02	_16	30		_ 50	
	how at		10a. State 10b. County		10c. City, T									1		City Limits
	e Ma-fs	cto	MD , NA		В	altimore									1 X Y€	s 2 No
	or 28	Dire	10e. Street and Number				10f. Zip C					1	0g. Citizen of		try?	
	ath w s 23a nust i	ra	4751 Ivanhoe			1.0		212						S.A.	!!:	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	y Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Fore	² X No		Was Decede If Yes, specif 1 ☐ Yes 2		spanic Origi n, Mexican, Specify:	n? (Spe Puerto	ecity Yes Rican, et	or No- c.)		ace - Americ ack, White, ify: R1		
Baltimore, Maryland 21215-0036	"natural	Completed by	15. Decedent's (Specify only highest	Education		(Give	dent's Usual	done di	uring most d	of worki	ng		16b. Kind of Johns	Business/Inc	lustry	
12	withir	E G	Elementary/Secondary (0-12)	College (1-	4or 5+)		oo not use Labor		!				_	_		
2	filed Hygid		10th grade 17. Father's Name (First, Middle, La	na est)			Labor		18_Mother	s Name	(First, N	liddle, l	Hospi Maiden Surna	.tal me)		
an	d be ental ced o	o Be	17. Father's Name (First, Middle, La Dixon John Dickson	,					Nancy Nane	e _V	Bla	ke		,		
₹	should and Men s marke umatic	ပ္	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (5	Street a					, City or Tow	n, State, Zip	Code)	
Š	1 and 2 Health a em 27 is		Maggie Davis-	Sister		7625	Amos	. Aı	re,Se	ver	n,	Mar	yland	21	144	
Ē,	s 1 a of Hea		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name	of	i		Date		20c. Location		wn, State	
E	Page nent c int: If		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		itate I			•	· :	11/	/26/	07	Owing	gs Mi	lls,	Md
Balt	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other	1	21. Signatur of Funeral Service Lic	censee Aug	H	M 4	arch	Address F/F Jaba	s of Facility H Wes	t ve,	Ва	lti	.more,	Md	212	15
			23a. Part1. Enter the disease, or connect, or heart failure. List or	omplications that ca nly one cause on ea	used the death. I	Do not ent	er the mode	of dying	, such as c	ardiac o	or respira	tory arr	est,		Approxim Interval E	ate etween
	Physician		Imm diate Cause (Final dist ase or condition	Lung	_	~ W	1 dt.	700	in m	etas	tas	LS			Onset an	d Death
	/Medical		resulting in death)	Due to	r as a consequen											
	Examiner		Sequentially list conditions, Due to (or as a consequence of):													
	ed sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury	Due to (d	or as a consequen	ice of):										
	xecut and Il-tran	хап	that initiated events c. Due to (or as a consequence of):													
8760,	cate be executed oblysician and the burial-transit	alE														
687		edical		d												
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		come pf pregnancy								23d. [ate of delive	erv	
Division or Vital Records, P.O. Box	death e atte d for	cia	in the past 12 months?	4☐Pregna	rth 2 □ Fetal de ant at time of deat		⊒Ectopic preց]Other <i>(spe</i> ն						1	/lonth	Day	Year
o	t the o	hys	9 Unknown	9□Unkno	wn											
Ω̈́	s tha	by P	Part II. Other significant condition	s contributing to dea	ath but not resultin	ng in the u	nderlying cau	se give	n in Part I.		23e	. Did tol	bacco use co	ntribute to t	ne cause c	f death?
ğ	equire en sig	edk										1 🗆 Y	es 2 No	3 🗌 Prot	ably 4 [Unknowr
၁၁	law re as be	Completed									24a	Was a		. Were auto	psy finding	s available
œ —	The ate has page	mo.									10	perfor	med? 2 Z No	death? 1 ☐ Yes	2 □ No	Cause of
/ita	slan; ertific ctor,	Be (25. Was case referred to medical examiner?						26. Place o	of Death	(Check	only on	re)			
<u>></u>	Attending Physician; r death. ector: After this certifica by the funeral director, I	입	1 ☐ Yes 2 ☑ No			<u> </u>	nt 3□ DOA		4 🗆 Nurs	sing Ho	me 5□] Reside	ence 6 🗹	ther (Specia	W HOS	ATIENT
בֿ	ing P		27. Manner of Death 1 ☑Natural 5 ☐ Pending		f Injury 28 h, Day Year)	3b. Time o Injury		c. Injury Work			28d. Des	cribe h	ow injury occ	urred		
Sio	tend leath. tor: / the f	Certification:	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	ho			М		′es 2 □ N	-	28f. Location (Street and Number or Rural Route Number,					
\leq	or Al titler d Direct in by	ijĘ.	4 Homicide determine	ed 28e. Place of buildin	of injury - At home ig, etc. <i>(Specify)</i>	e, tarm, str	eet, factory, (office		1			treet and Nur n, State)	nber or Hura	ii Houte N	umber,
_	pital		29a. Certifier 1 Certifying	Physician: To the I	hest of my knowle	teah anha	h occurred at	the tim	o date and	Inlace	and due	to the c	auca/c) and	mannor ac c	tatod	
	Hos 24 hc Fun etely	Medical	(Check only 2 Medical Ex	caminer: On the ba	sis of examination	n and/or in	vestigation, i	n my op	pinion, death	h occur	red at the	time, d	late and plac	e, and due t	o the caus	e(s)
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Me	29b. Signature and title of certifier				29c. I	License	number			2	9d. Date sigi	ned (Month,	Day, Year)
1	- S + O		> NIDL	~ ():()	Ω		D	140	476				11.13.	2007.		
1	0		30. Name and address of person wh	no completed cause	of death (Item 23	Ba) (Type.	Print)							,		
1	U		RAYMOND W. WILS	10. M.D.	6565 14 5	HARL	, TE 23.	STE	416,	BAL	TIMO	26	WD .	21204		
	Sta	te	31. Date filed (Month, Day, Year)	A. Re	egistrar's Signature											
	Registr	ar	MOV 2 0 28	07	123 E	Best.										

at

Died: 11/16/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	(Certificate of	Death	Reg. No. 2007 37072						
	Dharaisi		1. Decedent's Name (First, Midd	le, Last)			-	2. Date of Dea	ath Day	Year	3. Time of	Death	
÷ .	Physicia /Medic		Bar	bara Ann Ro	se			Nov. 18		1601	3:00	P M	
Exami			4a. Facility Name (If not institution		4b. City, Town, o	r Location of Death	1	4c. Count	y of Death				
<i>b</i>			4528 Springwood			i i i i i i i i i i i i i i i i i i i	Baltimor			Balt			
	Funeral Director		5. Social Security Number 213-42-4128 Usual Residence of Decedent	6. Sex 7. Age	(In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat Apr. 20	, 1942	9. Birthp Court Mary	place (State of htry) Vland	or Foreign	
	/land ow at		10a. State 10b. County	,	10c. City, Town	or Location				1	0d. Inside C	ity Limits	
	Mary I-f sh	ţ	Md.	Baltimore			Baltimor	e			1 ☐ Yes	2 XX No	
	h the r 28a r noti	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?		
	th wit	Funeral Director	4528 Springwood	Avenue			21206			USA			
	r dea	nue	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	- 14. Ra Bla	ce - Americ			
Baltimore, Maryland 21215-0036	should be filed within 72 hours after death with the Maryland not Mental Hyglene. In marked other than "natural", or Items 23a or 28a-f show matic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2 No	Specify:		Specia	fy:	White		
<u>2</u>	"natu	Completed	15. Deceder (Specify only higher	nt's Education est grade completed)	16a. E	Decedent's Usual Occup Give kind of work done life. DO NOT use retire	pation during most of wor	king	16b. Kind of E	Business/Ind	dustry		
12	within	m	Elementary/Secondary (0-12)	College (1-4or 5-	-)	Homen			Osar	n Home	,		
d 2	Hygie Hygie ther int, th	ပ္သ	17. Father's Name (First, Middle	Last)		Homen	18. Mother's Nan	ne (First, Middle,			=		
au	d be ental ked o	To Be	Geor					Sarah	Dixon	,			
ary.	shoul nd M mar	F	19a. Informant's Name/Relation		19b. I	Mailing Address (Street	and Number or Ru			, State, Zip	Code)		
Š	1 and 2 Health a sm 27 is ther trai		Vincent J. Rose	, Jr./Husband	452	28 Springwo	od Avenu	e Balti	more, N	/aryla	and 21	206	
e,			20a. Method of Disposition	0		Disposition (Name of crematory or other place		Date	20c. Location				
Ĕ	Pages nent of I ant: If Ite		1 ☐ Burial 2 🂢 Cremation 4 ☐ Donation 5 ☐ Other (Service Co	rp. 11/	24/07	Towson,	Mary	/land		
alt	spartr spartr sports y Inj	i	21. Signature of Funeral Service	License	1/	22. Name and Addre	ess of Facility R	uck Tows	on Fune	eral H	lome,	Inc.	
	205 20		Micha	of Thees	1	1050 York	Road To	wson, Ma	ryland	21204	ļ		
	Physician /Medical Examiner		Immediate Cause (Final disease or condition	r complications that caused t only one cause on each lin	the death. Do no	2.00	ng, such as cardiac	or respiratory ar	rrest,		Approximatinterval Bet Onset and	tween	
			resulting in death)	Due to (or as a	consequence of):							
Ţ		<u>_</u>	Sequentially list conditions, b. Due to (or as a consequence of):										
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Observe on injury										
	rdificate be executed ing physician and s as the burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):										
68760	e be (sicial	cal		d									
9	tificat g phy as th	Medical											
D. Box	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 ☐ Live birth : 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	у			ate of delive	-	Year	
Vital Records, P.O.	that ned by deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							co use contribute to the cause of death?			
rds S	quires n sigr Jid be	d by						1 🗆 '	Yes 2 No	3 ☐ Prob	oably 4 □	Unknown	
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Ä	sician: The law certificate has t irector, page 2 s	mo						autor perfo 1□ Yes	osy ormęd? 2 23 No	death?	mpletion of c 2□ No	ause of	
ta	lan: rtifica	Be Co	25. Was case referred to medical	al			26. Place of Dea	th (Check only o			2 140		
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0	ng Pt fter th		27. Manner of Death 1. Natural 5 □ Pendi	28a. Date of Injur (Month, Day	y 28b. Tii Year) Inj	ne of 28c. Injury Wor	ry at rk?	28d. Describe I	how injury occu	irred			
Sio	tendi eath. tor: A the fu	catic	2 Accident invest	igation not be			Yes 2 □ No						
Division or	To the Hospital or Attending Physician: The within 24 bours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	4 Homicide determ	nined 28e. Place of inju building, etc	ry - At home, farn . <i>(Specify)</i>	n, street, factory, office		28f. Location (3 City or Tox	treet and Number or Rural Route Number, n, State)				
	To the Hospital or / within 24 hours after To the Funeral Direction of	Ce	29a, Certifier 1 Certify	ng Physiclan: To the best o	f my knowledge	death occurred at the ti	me date and place	and due to the	cause(s) and n	nanner ae e	tated		
	24 hos 24 hos Fun etely	edical	(Check only 2 Medica one)	Examiner: On the basis of and manner sta	examination and	or investigation, in my	opinion, death occu	irred at the time,	date and place	, and due t	o the cause(s)	
	Го th within Го th	Me	29b. Signature and title of certifi-	er		29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)		
	/		1 Land	MO	i	Do	Neil	sv. 19, 2007					
1	7		30. Name and address of person	who completed cause of de	ath (Item 23a) (T		13172					,	
U	ÿ.		Lise Sat	re-field 5		mont A	ve, Ta	Son, de	10 2	128	6		
	Sta		31. Date filed (Month, Day, Year		r's Signature	South							
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** ITICHELL 22:35 PM . KUTKOWSKI NOVEMBE 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HORKINS BAYVIEW MEDICAL CENTER ALTIMORE If Under 1 Months If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan 27, 1927 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours Maryland 1 € M 2 □ F 80 Yrs. Director 219-10-2109 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. tnside City Limits ir then "netural", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2√2 No **Funeral Director** MD Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If them 27 is marked other then "netural", or items 23s any injury or other traumatic event, the Mentions 23s once. 7104 Fait Avenue 21224 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced 50-52 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) O foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Paul Rutkowski Helen Rutkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7104 Fait Avenue Baltimore, MD 21224 Stella Rutkowski/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ronal Licensee S.W. State Anatomy Board 655 W. Baltimore Street mn Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATURY **Physician** FAILURE /Medical Due to (or as a consequence of) Examiner EPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed ENDOCARDI physicien and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1□ Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Ptace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA this s after death.
I Director: After this
of in by the funeral d 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funerel C filled 1 Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signalure and title of certifier KES-000 NOVEMBER 13, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE BALTIMORE MD 21724 M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

NOV2 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Elisabeth Mary Rodert November 18, 2007 5:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Martin's Home Baltimore Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/06/1916 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🛣 F Maryland Yrs. 91 Director 219-16-4510 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 XNo Director Maryland | Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must once. 601 Maiden Choice Lane #415 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5 Book Keeper Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျှ Edward Henry Rodert Anna Mary Kalbfleisch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Mary Lou Kasten - Friend</u> 5210 Old Frederick Road Baltimore, Maryland 21229 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Most Holy Redeemer 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/23/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Service Lic of ee David J. Weber Funeral Homes P.A. Namer 5311 Edmondson Avenue Baltimore, Maryland 21228 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure distance on each line. Immediate Cause (Final Physician CONGESTIVE 413 disease or condition resulting in death) HEART /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last COKANAKY Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∏ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural Injury 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760

within 24 hours after death

To the Funeral Director: completely filled in by the f

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHRISTING

MOV 2 0 2007

32. Restrar's Signature

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DO025844

5411 OLD FREDEREK RD

29d. Date signed (Month, Day, Year)

NOV. 19, 2007

Medical

State

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

			FOR	partment of Health and Nertificate of Death	Mental Hygie	2001 31015
ı	Physicia	an	1. Decedent's Name (First, Middle, Last) Lucile Frances Roeder		2. Date of Death Month November	Day Year 3. Time of Death 4:15 PM
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number) Pickersgill	4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore
8	Funeral Director		5. Social Security Number 219-10-2195 Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, You May 22, 1	ear) 91.5 Birthplace (State or Foreign Country) North Carolina
	be filed within 72 hours after death with the Maryland the Hydjene. d other than "neturel", or tems 23c or 28e-f ehow event. If a Madical Examiner, and be matted at	Funeral Director	Maryland Baltimore 10c. City, Town of Towson	1		10d. Inside City Limits 1 □Yes 2 ☒No Citizen of What Country?
	with the	Dire	10e. Street and Number	10f. Zip Code 21204		nited States
	ns 23	eral	615 Chestnut Ave. 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,
030	urs after d el', or Iten Examiner	by	Amed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc. Specify: white
212-0030	thin 72 ho e. "netur Madical	Completed	(Specify only highest grade completed) ((Specify only highest grade completed) ((Specify only highest grade completed)	ecedent's Usual Occupation live kind of work done during most of work e. DO NOT use retired)	king	b. Kind of Business/Industry
7	led wii lygien her th			registered nurse	e (First, Middle, Ma	medical
/land	d tal	To Be	17. Father's Name (First, Middle, Last) Oscar Julius Lane	Della H	ughes	
Mar	permit. Pages 1 and 2 should I Department of Health and Men Importent: If item 27 is marke eny injury or other treumetic once.	and a second		Mailing Address (Street and Number or Ru Winterfield Ct. N	ewark, DE	4
e e	es 1 a of Hei		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition	crematory or other place)		c. Location - City or Town, State
aitimore,	t. Pages tment of tent: If it		`4 □Donation 5 □Other (Specify) Maplewo		Control of the last of the las	t. Olive, North Caro.
g	Depar Impor eny ir		21. Signature of Funeral Service Licensee Janu D. Mutchell The service Licensee The s	22. Name and Address of Facility ede Mitchell—Wiede 6500 York Rd.	Baltimo	re, MD 21212
	Prrysician /Medical Examiner		23a. Park. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	enter the mode of dying, such as cardiac security of CSS+ruces:		Approximate Interval Between Onset and Death
, , , o		al Examiner	Sequentially list conditions, if any leading term a liab cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to for as a consequence of c. C. Due to (or as a consequence of c.)			
98760	ficate to physical ph	edical	d.			
O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
ds, P.	uires that the de n signed by the a lid be detached i	by	Part II. Dther significant conditions contributing to death but not resulting in the significant conditions.	he underlying cause given in Part I.		cco use contribute to the cause of death? 2 🗆 No 3 🗀 Probably 4 🗀 Unknown
Records,		Completed			24a. Was an autopsy performe	
Vita	cien: ertifica ector,	Be (25. Was case referred to medical examiner?		th Check onl one	
	Physi this c al dire	- To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp		ome 5 Residen	ce 6 Other (Specify)
O	ding Ph th. After th funeral	tion		ne of 28c. Injury at Work? M 1 Yes 2 No		.,,
Division of	I or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
-	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medicel Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
ì	To the within To the compl	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month. Day, Year)
	6		30. Name and address of person who completed cause of death (Item 23a) (7	ype, Print) (Purle St	Balts i	10 venber 16, 2007 Ud 2, 205
- 0		ate rar	31. Date filed (Month, Day, Year) NOV 2 0 2007	bast 1	16.	
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AMEND Item#7 per FH G873 11/21/07 WS

State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year EMMA REDMOND ELIZABIETH 15 A M 18 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PIKESVILL BALTIMORE COURT ARDEN If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. August 23,1916 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2/XF Marviand 216-01-9767 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 □ Yes 🏋 No Baltimore Pikesville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 USA 8909 Reisterstown Road Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes **20** No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2XX No Specify: Completed by ₩ Widowed 4 Divorced Specify. White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marriott Marcella Holmes George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barry M Redmond Son 315 East Timonium Road Timonium Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Gardens: 11/20/07 Timonium Maryland Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John O Mitchell IV Funeral Services of ignature of Funeral mnis D Dulaney Valley 200 East Padonia Road Timonium Maryland 21093 23a. Part1. Enter the diserve, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ZHEIMEK disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Division or Vital Records, P.O. Box 68760, 4 Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page perform 2 No or Attending Physician: funeral director. Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 I Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: 2 ☐ Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H45931 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith Avonue Pikesville MD More Detorah I 32 egistrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 0 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

•			For State Registrar	State of Maryland	•	tificate of			Reg. No. 2	007	370	177
	Physicia	an	1. Decedent's Name (First, Middle, L	ast)				Date of Dea Month	Day	Year	3. Time of E	
	/Medic	al	Michael A.	Romeo Jr.		4h City Town o	r Location of Death	Novembe:		2007 unfy of Death	11:33	PIVI
	Examin	er	4a. Facility Name (If not institution, g	ve street and number)						nne Aru	ndo1	
	Funeral		105 Nursery Rd. 5. Social Security Number 6.	Sex / 7. Age (In yrs. I	ast birthday)	Linthi If Under 1 Year		8. Date of Birt (Month, Day	h	9. Birthp	lace (State or try)	Foreign
- 1	Director		216-32-9229	10M 2□F 71	Yrs.	Months Days	Hours Min.	Dec 30			yland	
	pu. »		Usual Residence of Decedent 10a. State 10b. County	10c City	. Town or Loc	cation			•		0d. Inside City	y Limits
	ter death with the Maryland Items 23a or 28a-f show Iner must be notified at	ctor	Md. Anne Ar		nthicu						1 □ Yes	
	or 28	Dire	10e. Street and Number			10f. Zip Code				of What Coun	try?	
	sath v	eral	105 Nursery Rd	12. Was Decedent Ever in U.	S 13 V	Vas Decedent of H		cify Yes or No		S.A. Race - Americ	an Indian,	
036	after or ite	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces?		f Yes, specify Cub:	lispanic Origin? (Spe an, Mexican, Puerto l Specify:	Rican, etc.)		Black, White, pecify: Whi		
S. C.	72 hours "natural",	etec	15. Decedent's (Specify only highest of	Education rade completed)	16a. Deced (Give	lent's Usual Occup kind of work done	oation during most of workind)	ng j	16b. Kind	of Business/Ind	fustry	
- Z	vithin ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			a)		Stee	o 1		
0\ p	ygi t,	ပ္ပိ	10 17. Father's Name (<i>First, Middle, La</i>	st)	Main	tenance	18. Mother's Name	(First, Middle,				
an	id be ental ked o	To Be	Michael A. Ro	meo Sr.			Rebeco	ca (Cannor	n		
ar J	d 2 should be filed th and Mental Hygi 7 Is marked other traumatic event, II	۲	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailin	g Address (Street	and Number or Rura	I Route Numbe	er, City or To	own, State, Zip	Code)	
OZ	and 2 ealth a n 27 is ier tra		Lisa Romeo da	ughter	4016	Baltimo:				1d. 212		
t/	of He		20a. Method of Disposition 1 → Burial 2 → Cremation 3	20b. P	lace of Dispo emetery, cren	sition (Name of natory or other pla	ce)	Date		tion - City or To		
14 /	Pages Iment of I Iant: If Its Jury or o		4 □ Donation 5 □ Other (Spec	city)			tery 11/19	9/07	Crowns	sville,	Md.	
$0.01/14/0.07$ \odot Baltimore, Maryland	permit, Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		21. Signature of Funeral Service Lic	am in sunhi		. Name and Addre	ess of Facility Gor hie Hgwy			Service		
6			23a. Part1. Enter the disease, of co shock, or heart failure. List on	mplications that caused the deatl	n. Do not ente	er the mode of dyi	ng, such as cardiac o	or respiratory a	rrest,	L	Approximate Interval Betw	ween
	Physician		Immediate Cause (Final disease or condition	LUNA	101	OCEN	with	1110	M	019	Onset and D	eath
	/Medical		resulting in death)	Due to (or a a nseq	uence of):		411					
	Examiner	L	Sequentially list conditions	b. Due to (or as a conseq	ufte seens							
J	ted nsit	Examiner	Gauer tially list our discrete if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	derice ory.							
^-	tificate be executed g physician and as the burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):						-	
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. Ø O. Box	ne death cer the attendir hed for use	by Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown	Ideath 3	Ectopic pregnanc Other (specify) _	у		230	d. Date of delive Month		Year
ds. P	w requires that the seen signed by should be detact	d by Pr	Part II. Other significant conditions	s contributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.		obacco use Yes 2□	contribute to t	he ause of de bably 4 □U	
ر میر Record	w red s beer shou	Completed						24a. Was	an :	24b. Were auto	psy findings a	available
_	The law te has age 2 s	omp						auto perfo 1∐ Yes	rmed?	prior to co death? 1 🔲 Yes	mpletion of ca 2 □ No	ause of
الالالا Wital		Be C	25. Was case referred to medical				26. Place of Death		ne)	, , , , ,		
) >	Physical this ce al direc	To B	examiner? 1 ☐ Yes 2 7 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	t 3□ DOA Ott	ner: 4 Nursing Ho	me 5 🗗 Resi	dence 6 [□Other (Speci	fy)	
	ng l	:uo	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe	how injury o	occurred		
Si Si	tendileath.	cati	2 Accident investigat 3 Suicide 6 Could not	be See Blees of injury At he	mo farm etr		Yes 2□No	28f Location (Stroot and I	Number or Run	al Route Num	her
77 Division	after of Direct of Jin by	Certification:	4 ☐ Homicide determine	building, etc. (Specif	у) у)	eet, factory, office		City or To	wn, State)	variber of Hun	a noute num	Der,
	To the Hospital or Attendil within 24 hours after death. To the Euneral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the t vestigation, in my	ime, date and place, opinion, death occur	and due to the red at the time,	cause(s) ar date and p	nd manner as s lace, and due t	stated. to the cause(s	5)
	To the within to the comple	Mec	29b. Signature and title of certifier	1	1 -	29c. Licens	se number		29d. Date :	signed Month,	Day, Tear)	
	r s r o		1 White 11/	Mane MI	7	Pla	30/2		11	115	111	
	121		30. Name and address of person w	o completed cause of death (Item	23a) (Typé,	Print)	10/0	2.16	MI	11-1	4	
	21'		John Will	MOE 47/10	MARI	Wedy	MA	7/10,	////	2/0	2/8	<u> </u>
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrat's Signa	ture	de la	,,				•	
	riegist	aı	IVIII V / V L	JOI HONGSON TO THE	C 1							

obert Rankin	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. Reg. No.	3707
Physician ledical Examine	1. Decedent's Name (First, Middle,Last) Robert B. Rankin 2. Date of Death Month Day Year November 16, 2007 3. Time of 0730	1
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1521 Church Street Ac. County of Death N/A	
Funeral Director	5. Social Security Number 220 84 8690 1X M 2 F 41 41 Yrs. 41 Yrs. 5. Date of Birth (MWDD/YYYY) 9. Birthplace (State of Birth (MWDD/YYY) 9. Birthplace (State of Birth (MWDD/YYY) 9. Birthplace (State of Birth (MWDD/YYY) 9. Birthplace (State of Birth (MWDD/YY) 9. Birthplace (Sta	
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside	e City Limits
<u> </u>	Maryland Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country?	s 2 X No
the Mary	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 U.S.A.	
11 UTTT D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 33a or 28a-f sho latte event, the Medical Examiner must be notified at once.	11. Marital Status 1	Black,
ours after	or Dates: 16. Mind of Business/Industry 16. Decedant's Usual Occupation (Give kind of work done	
5-0036 led within 72 h Hygiene. other than "r	15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest grade completed) 16. Decedent's Social Occupation (Specify only highest	
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D 2121(should be fill and Mental J is marked natic event,	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
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- 트 교 를 보 b	4 Donation 5 Other Specify: Cedar Hill Cemetery 11/21/2007 Baltimore, Mar	
Balt permit. Depart Impor injury	Leone Manusculli 4001 Ritchie Highway Baltimore, Maryland	21225
Physician /Medical	failure. List only one cause on each line.	mate Interval en Onset and Death
aminer	Immediate Cause (Final disease or condition resulting in death) a. Heroin and cocaine intoxication Due to (or as a consequence of):	
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
executed an and al - transit	if any, leading to immediate output Discripting Coupe (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.	
sici sici	V UNPENDED	
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P.O. B as that the degreed by the detached the detached the detached the Dr.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4	
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Recol The law cate has l	24a. Was an autopsy find prior to completion death? 1 Ves 2 No 1 Ves	2 No
Vital Rechysician: The this certificate	25. Was case referred to medical 25. Place of Death (Check only one) We saminer? Hospital: 4 Innation 3 DOA Other, Nursing Home 5 Residence 6 Other Scene	
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ivision or Atten after death Director:	Natural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide 4 Homicide 5 Specify) Other Scene 1 Yes 2 X No unk unk with the factory, office building, etc. (Specify) other Scene 1 Section 1 Yes 2 X No unk unk unk with the factory office building, etc. (Specify) other Scene 1 Section (Street and Number or Rural Route or Town, State) 1 Section (Street and Number or Rural Route or Town, State) 1 Section (Specify) other Scene 1 Section (Street and Number or Rural Route or Town, State) 1 Section (Specify) other Scene 1 Section (Specify) Section (Sp	
To the Hospital within 24 hours: To the Funeral completely filled	1 298, Celliller 1 a .	
To the comple	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, V	
	30. Name and address of person who completed cause of death (Item 29a)	
	Zabiullah Ali, M.D. Assistant Medical Examiner (111 Penn Street, Baltimore, MD 21201	
Stat Registra	1V(11V Z. 11 /11V1/1 AAZASSAPPA	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 7:00 P M November 18, Aquilino Singh 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 10214 Sea Pines Drive Prince George's Mitchellville if Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1**X** M 2□ F 85 Director 214-15-0660 Oct. 15. 1922 Philippines Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Directo Maryland | Prince George's Mitchellville the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 10214 Sea Pines Drive 20721 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2反 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after a mort of Healih and Mental Hygiene. Interfile mort is enemy in the more 27 is anacked other than "natural", or the ury or other traumatic event, the Medical Examiner ury or other traumatic event, the Medical Examiner. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2☐No þ Specify. 3X Widowed 4 ☐ Divorced Year or Dates: Philippine Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Philippine Tobacco Security Guard 4 Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bola Singh ၉ Gullerma Bautista 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ranjeet Singh/ Son 10214 Sea Pines Drive Mitchellville, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If Ite any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan 4 ☐ Donation 5 ☐ Other (Specify) 11/23/2007 | Alexandria, VA Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician a Poorly Differentiated Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ohysician and the burial-transit Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical use as t attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Hypertension, Coronary Artery Disease, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Benign Prostate Hypertrophy, Gastritis 24a. Was an has autopsy performed page 1∐ Yes 2X□ No or Attending Physician; funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 ☐ Pending investigation (Month, Day Year) Injury 1X Natural 1 □ Yes 2 □ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) 4 Homicide Hospital 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29b. Signature and time of certifier 29d. Date signed (Month, Day, Year) D29671 November 20, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6501 Landover Road Cheverly, MD 20785 Villamor S. Reyes, M.D. 31. Date filed (Month, Day, Year) NOV 2 0 2007 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ovembe .7:30A M /Medical 4a. Facility Name (If not institution, give street 4b. City, Town, or Location of Death Examiner Columbiald Harmom 8. Date of Birth (Month, Pay, Year) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Min. North Carolina 1 □ M Director 578 30 5345 83 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2√√No Director Columbia Marvland | Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 21044 United States 6336 Cedar Lane #350 Funeral ral", or items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 shruld be filed within 72 hours after onent of Health and Mental Hygiene. ont: If item 27 is marked other than "natural", or item NUNever Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📆 💥 o Specify. þ White 3 Widowed 4 Divorced Year or Dates: Completed event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Poplin John Bartlett Burcham, Sr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russ Sharpe (SON) 7614 Stratfield Lane, Laurel, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory Nov 20, 2007 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandira Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 and **Physician** /Medical Examiner Sequentially list conditions, Due to for as a ponsequence of Physician/Medical Examiner dary, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of) physician are the burial-t Division or Vital Records, P.O. Box 68760, as attending IF FEMALE use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pertormed? Yes 2 No 2□ No 1 TYes or Attending Physician: 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1) Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifi

005 32/Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

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sell land clarified MD 21029

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 19, Catherine S. Scarborough 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Eldercare Gardens Linthicum Anne Arundel 8. Date of Birth (Month, Day, Mar. 18 Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1□M 2 F Months Hours 216-01-0496 98 1909 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 Chestnut Road 21090 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. Specify: White ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Seafood Elementary/Secondary (0-12) College (1-4or 5+) Office Worker Distributor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Odensos Annie Harald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29539 Connelly Mill Rd., Delmar, MD 21875 Errol Wood - Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 11-21-2007 Baltimore, MD Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) PEREBROVASCI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 🕱 No 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No performe MYOCARDIA 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dether (Specify) 2[* No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Funeral

Director

28a-f show notified at

them 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be re-

permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: If them 27 is marked other any Injury or when

within 72 hours after death

3altimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

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Certification:

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and physician signed by t d be detach has certificate After this To the nospiral within 24 hours after death.

To the Funeral Director: Aft

9 ☐ Unknown	9 CONKNOWN	
Part II. Other significant condition	ns contributing to death but not resulting in the un-	derlying cause given in Part I.
VERY Adva	ns contributing to death but not resulting in the unit	2CT DeME

25. Was case referred to medical examiner? 1 🔲 Yes

5 Pending investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ATTENDING PHYSKIA

NOV 2 0 2007

29c. License number D16200

NOVEMBER

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAIDEN CHOICE NORBERTO M. MACHIRAN, MD 720 C 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State Registrar	State of N	Marylan	•	artment <i>rtificate</i>			lental Hy	giene Reg. No	200	37082
ight:	Physici	an	1. Decedent's Name (First, Middle, Las	,				_		2. Date of De	ath Da	ay Year	3. Time of Death
	/Medi	cal	Elizabeth 4a. Facility Name (If not institution, give	L.	er)	Sp	orik	own, or Lo	cation of Death	Novemb		. County of Dea	
	Examir	ier	Greater Baltimor	e Medica	1 Cen		To	wson				Baltimor	
	Funeral Director		5. Social Security Number 6. Security Number 1	ex □M 2[X F 7.7	Age (In yrs. 7 3	last birthday) Yrs.	If Under 1 Months		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da January	rth a <i>y, Year</i> ' 31, 1	9. Bi	rthplace (State or Foreign Jountry) Insylvania
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	Maryli I-f sho fied at	tor	Maryland Baltimo	re		oundalk	2						1 ∐Yes 2 No
	th the or 28a e noti	Director	10e. Street and Number				10f. Zip (Code			10g. Ci	tizen of What C	country?
_	ath wi		7000 Belclare Roa		.=			2122				JSA	
120beth	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ ♠ ivorced	12. Was Deceder Armed Force 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	s? ⊠No		Was Decede If Yes, specif		anic Origin? (Sp Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	D-	14. Race - Am Black, Wh Specify:Wh	ite, etc.
1120be	.⊆ - ⊒	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12 years	ucation de completed) College (1-4a	or 5+)	(Give life.	dent's Usual kind of work DO NOT use	Occupation during retired)	n ng most of work	ing		kind of Business	
, , , ,	filed Hygie other	Be Co	17. Father's Name (First, Middle, Last)				ricar	18	. Mother's Name	e (First, Middle			LOIS
yla_	should be ind Mental imarked c	일	Edward Albert Tit	tiger								enrider	
Sport CE	ges 1 and 2 should be filed with to f Health and Mental Hygiene. If item 27 Is marked other that or other traumatic event, the Merchen that the Merchen traumatic event, the Merchen traumatic event, the Merchen traumatic		19a. Informant's Name/Relationship (7 Cindy Wynn	_{Type. Print)} Daughtei	r	1						or Town, State, Marylar	
ore,	jes 1 a t of He If item or othe		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □	Removal from Sta		Place of Dispo cemetery, cre	matory or oth	ner place)	Nove			ocation - City o	
	Pa Int:		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Fungral Service Licen)	Mea	dowrid			- 20,	2007		dalk,P. <i>l</i>	, Maryland _
B	permit. Departr Imports any inji		Enthony (onne	elly		7110 S	oller	s Point	Road,	Dung	dalk, Mo	21222
	Physician /Medical		23a. Part1. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. 1465	Milni	m/f	ter the mode	of dying, s	such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
68760,	Examiner be executed physician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	as a consequence as a c	uence of):	JON	70					
P.O. Box 6	at the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 norths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1⊡Live birth 4⊡Pregnant 9⊡Unknowr	n 2 ☐ Feta t at time of c	al death 3	⊒Ectopic pre ⊒ Other (spe					23d. Date of do Month	elivery Day Year
rds, P.	w requires that been signed by should be deta	þ	Part II. Other significant conditions of	ontributing to death	n but not res	ulting in the u	inderlying ca	use given i	n Part I.				to the cause of death? Probably
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ō	y Physer this eral di	: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Vi	njury	28b. Time of		c. Injury at Work?		me 5 ∐ Res 28d. Describe		6 □Other (Sp ury occurred	ecify)
ion	ending lath.	atior	1 Natural 5 Pending investigation		Day Year)	Injury	М		s 2□No				
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	e Hospital 24 hours a e Funeral I letely filled	Medical (29a. Certifier Check only one) Certifying Phracies Certifier Certifying Phracies Phracies Certifying Phracies P	ysician: To the be niner: On the basis and manner	s of examina	owledge, deat ation and/or in	th occurred a nvestigation,	it the time, in my opin	date and place, ion, death occur	and due to the red at the time	cause(s) and manner and place, and do	as stated. ue to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	10	2	>	29c.	License ni		330	29d. Di	ate signed (Mor	11th, Day/Year) 1-/2007
	10		30. Name and address of person who	completed cause o	of death (Item	n 23a) (Type,	Print)	50 L	Touse		21	20U	() /
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regi	istrar's Signa	ature	الله م		1000sc	<u>~, M</u> 0	· 01	~7	

NOV 2 0 2007

DHMH 17 Rev 1/2001

Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 100 19 and Deba8873 to Tean Tark Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Russell Sanders 10:20 PM NOV 2007 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. AGNES HOSPITAL BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F 242-24-3371 Director 23 84 04 26 NC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Items 23a or 28a-f sho ner must be notified at 1X Yes 2 No Baltimore Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 720 Lyndhurst Street 21229 U.S.A. Funeral filed within 72 hours after death Hygiene. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No þ Specify: Black 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) O'Donald Pontiac Truck Driver 9th grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 Is marked oth any Injury or other traumatic event 2009. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth McClamb Russell Sanders 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
720 Lynnurst Street, Baltimore, Md 21229 Vivian Robinson-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 11/24/07 Woodlawn Baltimore Co, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee U. 4300 Wabash Ave, Baltimore, Md 21215 3a. Part/ Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death In medic te Cause (Final di least or condition resulting in death) SEPSIS **Physician** 3 WEEKS /Medical Due to (or as a consequence of): Examiner PNEUMONIA 2 WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): MORE THAN DECUBITUS ULCER 2 MONTHS attending physician and for use as the burial-trar Due to (or as a consequence of): MORE THAN P.O. Box 68760 FAILURE RENAL Physician/Medical 2 MONTHS IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 □ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Oriknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ormed? 2 **™**No Division or Vital 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P21800 NOVEMBER 18, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PULICKEN, 900 S. CATON AVENUE, BALTIMORE, MARYLAND 21229 MATHEW 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

NOV 2 0 2997

ANDER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) November Physician 79, 2ďď7 8:05 Αм Maryne /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Oakcrest Care Center Parkville If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Pay, Year) B/7/1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F 88 Mařyľánd Yrs. Director 215-09-5383 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ¥ 1 ☐ Yes 2 No r 28a-f sh notified MD Baltimore Parkville Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number a or 8832 Wather Blvd Apt 317 21234 USA item 27 is marked other than "natural" or items 23a other traumatic event, the Medical Examiner must t Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed by 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meone. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental Albert Wyatt Regina Connelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jerry Schuerholz / Son Nottingham, MD 21236 6 Mora Court 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Gard. 11/21/2007 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21. Signature of Funeral Service Licenses 21204 Welle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ruck Towson Funeral Home, Inc. 1050 York Rd. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** *jement* /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (ursease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 1 sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA After this 27. Manufer of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending after death.

I Director; Af or ir by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled ir by 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier MD P61785 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) 8800 UQ
32. Registrar's Signature Walther Boulevard Parhville, MD 21234 State

Registrar

EXPIRE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 6. 2. 2.

			For State Of Maryland / D State Registrar	Certificate of L		Reg. N		37085				
7	Physicia	ın	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month November	Day Year	3. Time of Death				
1	/Medic	al 🦂	Christian C. Seibert 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death		1/, 200/	11:10 A.M				
	Examin	er ~	Catonsville Commons	Catonsv			Baltimo	re				
	Funeral Director		210-03-4310	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth Cou 1920 Mary	nplace (State or Foreign untry) 'land				
	vland ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	10c. City, Town or Location								
	e Man a-f sh iified	ctor	Maryland Baltimore Cat	onsville				1 ☐ Yes 2X No				
	a or 28	Funeral Directo	10e. Street and Number 1201 Pleasant Valley Drive	10f. Zip Code 2	1228		Citizen of What Cou USA	untry?				
	ems 2	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White					
5-0036	be filed within 72 hours after death with the Maryland ttal Hygiene. Ital Hygiene. Ital Hygiene Than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 X Married 1 X es 2 No If Yes, Give Year or Dates: 1942-45	1 ☐ Yes 2 ☑ No	Specify:		Specify:	hite				
2	יי 72 ה "natu edicai	letec		Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired)	uring most of work	ing 16b.	Kind of Business/I	ndustry				
7 7	J withir giene. r than the M	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Machinist	,	T	elephone					
/land	be filed tal Hyg d othe event,	BeC	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid	ŕ	_				
χ	should be and Menta marked umatic ev	ဥ	Christian Seibert 19a. Informant's Name/Relationship (Type. Print) 19b.	. Mailing Address (Street a		th Elliott		tin Codo)				
, mar	nd 2 lith a 27 is r trai		Verna A. Seibert Wife 12	201 Pleasant	Valley I	Orive; Cat	onsville.	, MD 21228				
ore,	ages 1 ar at of Hea If item or othe		1 Bunal 2 24 Cremation 3 Hemoval from State	Disposition (Name of ry, crematory or other place			Location - City or					
baitimor	permit. Pages Department of I Important: If ite any injury or o once.		4 □ Donation 5 □ Other (Specify) Metro 21. Signature of Funeral Service Licensee	Crematory 22. Name and Addres Funeral Hor	11/19 s of Facility Ste	/2007 Cate	onsville, ton Schwa	Maryland ab Witzke				
ă	permi Depar Impor any ir		· Chre Helt	1630 Edmon	dson Aver	nue; Caton	Inc. sville, N	4D 21228				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death									
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	Examiner											
18	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	of):								
	tificate be executed g physician and as the burial-transit	Examiner	that initiated events c. Due to (or as a consequence of	of):								
68/60 ,	ate be hysicia he bur	edical	d				-					
	certification ding places as t		IF FEMALE: 23c. If yes, outcome pf pregnancy				Old Date of deli	710-				
C. BOX	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3 ☐ Ectopic pregnency 5 ☐ Other (specify)			23d. Date of deli Month	Day Year				
ς, Τ	requires that the een signed by the rould be detache	by Pr	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause give	en in Part I.	23e. Did tobacc	co use contribute to	the cause of death?				
ecords,	require sen siç rould b		Cochexie			1 □ Yes	2 No 3 Pro	obably 4 🗗 Onknown				
al Kec	The la ate has page 2	Completed				24a. Was an autopsy performed 1 Yes 2	prior to death?	topsy findings available completion of cause of 2 \square No				
VII	ding Physician: The n, After this certificate ha funeral director, page	Be	25. Was case referred to medical examiner? Hospital:	trationt 25 DOA Othe		h (Check only one)						
ō	Phys er this eral dir	<u>1:</u>	27. Manner of Death 28a. Date of Injury 28b. T	Time of 28c. Injury	4 Mursing Ho	ome 5 Residence		cify)				
000	Attending Physician: r death, ector: After this certific by the funeral director.	atior	2 Accident investigation		(? Yes 2 □ No							
DIVISION	al or Attendes safter death	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, far building, etc. (Specify)	rm, street, factory, office		28f. Location (Street City or Town, St	and Number or Ru ate)	ıral Route Number,				
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ledical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and and manner stated.	id/or investigation, in my or	pinion, death occur	rred at the time, date	and place, and due	to the cause(s)				
	To th withir To th comp	Me	29b. Signature and title of certifier Afterdary	29c. License	6942		Date signed (Month	h, Day, Year)				
	3+1		30. Name end address of person who completed cause of death (Item 23a) (Type, Print)	cu. Cate	yville,	mo 2/2	-28				
	Sta Registr		29b. Signature and title of certifier 30. Name end address of person who completed cause of death (Item 23a) (31. Date filed (Month, Day, Year) NOV 2 0 2007 and manner stated. Attended the complete cause of death (Item 23a) (32. Registrar's Signature	Louis								
				.57								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year :37 P. /Medical ovember 12 2007 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day) (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 J Yrs. Director Hiso Usual Residence of Decedent 10c. City 10a. State 10b. County Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notifled at 1 Yes 2 No Director eet and Number 10e. 10f. Zip Code 10g. Citizen of What Country 10 Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 NO Baltimore, Maryland 21215-0036 'natural", or 211No 1 TYes þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DQ NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden S 17. Father's Name (First, Middle, Last) Be Department of Health and Meni Important: If item 27 is marker any Injury or other traumatic e ဂ္ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route N City or Town, State, Zip Code) nonica 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral pervice Lipin Name and Address of Facility 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** in known /monary /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 🖾 Únknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably funeral director, page 2 should Completed Cancer peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Inpatient 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of eath Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation Injury To the Hospital or Attendl within 24 hours after death. To the Funeral Director; A 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) germa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 Agnes 2. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV20 2007 Registrar

DHMH 17 Rev 1/2001

			State of Maryland / Dep	artment of Health and M <i>rtificate of Death</i>	lental Hygiene	2007 37087
L	-		Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
1	Physicia		Dora Louise Smith		Month Da	6 2007 12:00P ^M
V	/Medic Examin	211	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c	. County of Death
Jan 3	Examini	C1	1103 Armistead Street	Glen Burnie		Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	if Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
- 1	Director		214-24-5576 1□M 2\F 80 Yrs.		06/24/192	7 MD
	nd ,		Usual Residence of Decedent 10c. City, Town or L 10a, State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	aryla shov ed at	7	Too. State			1 □Yes ¾XXNo
	he M 28a-f otifie	Director	MD Anne Arundel	Glen Burnie	10a. Ci	tizen of What Country?
	with t	ä	1103 Armistead Street	21061		U.S.A.
	eath	eral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show thet, the Medical Examiner must be notified at	Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No		Rican, etc.)	Black, White, etc.
99	al", or	þ	3 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1 ☐ Yes 2 ☒ No Specify:		Specify: White
ŏ	2 hou	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work		Kind of Business/Industry
2	thin 7 e. an "r Med	adr.	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
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D	tal H d oth	Be	17. Father's Name (First, Middle, Last)			ii Suriaine)
<u></u>	ould Men arke	မ	George Albert Tucker, Sr.	Lana ling Address (Street and Number or Rui	Rae Jones	or Town State Zin Code)
Maryland 21215-0036	12 sh h and r Is m raum		Tod. Michigan of teamer load action (1) per 1 may	•		ttsville, MD 21104
a)	1 and Health					ocation - City or Town, State
وّ	ages it of l		1KJBurial 2 Cremation 3 Removal from State		'20/07 E	lkridge, Maryland
Baltimore,	it. Pa intmer intant njuny		77			W, Glen Burnie, MD
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		That A Varian Mo1357	Singleton Funeral		
			23a Part 1 Peter the disease, or complications that caused the death. Do not e			Approximate Interval Between
			shock, or heart failure. List only one cause on each line.	dorolic Uce		Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	aprone ou	0 CO KCO VI	is year
24	Examiner					
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Box	ath ce ttendi	an/	23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
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Division or Vital Records,	5 9 9 9	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ We Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	Other	ath (Check only one) lome 5 Residence	6 Other (Specify)
o	Phys r this ral di	<u>۲</u>	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how in	
on	ding F h. After funer	tion	1 □ Natural 5 □ Pending (Month, Day Year) Injur 2 □ Accident investigation	/ Work? M 1 ☐ Yes 2 ☐ No		
İSİ	Attend death.	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm,	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number,
ă	al or after after I Direct	Certification:	4 ☐ Homicide determined building, etc. (Specify)		ony or rown, on	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only (Check only 2 Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place	e, and due to the cause urred at the time, date a	r(s) and manner as stated. and place, and due to the cause(s)
	the H iin 24 the Fi	ledical	one) and manner stated.	29c. License number		Date signed (Month, Day, Year)
	To To	Σ	29b. Signature and title of certifier			
			Weffry Lalamo	1 1121012	-	111612001
	10		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	149 Wilter	whe Balknow, Mid
	V		31. Date filed (Month, Day, Year) 32. Registrar's Signature	JOVE 1111VJ. 0		W/16/2007 No Ave Baltinore, Mil
	St Regist	ate trar	NOV 2 0 2007	JOSAN S		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) **Physician** 1:00P M NOVEMBER /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner BALTIMORE WASHINGTON NEDICAL CENTER 8. Date of Birth (Month, Day, Year) 10/27/1928 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Min. 1□M 2\ F 79 Scotland 212-30-4062 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 No a or 28a-f shot be notified a Director Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21061 U.S.A. 716 Baylor Road or items 23a Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. traumatic event, the Medical Examiner 1 Never Married Married Specify: White 1 ☐ Yes 2XXXVo Specify. þ 3 Widowed 4 Divorced and Mental Hygiene. Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) filed within Hygiene. Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be i John Beaumont Jessie Gregg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is u 716 Baylor Road, Glen Burnie, Maryland 21061 Mr. Earl A. Sakowski / husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 11/20/2007 Crwonsville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Ave SW, Glen Burnie, MD Singleton Funeral & Cremation Services MO1357 ancier 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical to or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transit and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?

1 Yes 2 No 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown certificate has been signed by rector, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 21 No 1 Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ¹ 2∕⁄ No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of 28d. Describe how injury occurred Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide

within 24 hours after death

To the Funeral Director:
completely filled in by the i the

Baltimore, Marýland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2

and manner stated.

32 Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** SCHOONOVER DEBORAH KAY NOVEMBER14 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTMORE ELTY 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 1 M 2 F Director 223-64-0742 May 14, 1955 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show must be notified at 1 Mayes 2 □ No Directo Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? e filed within 72 hours after death with al Hygiene.
other than "natural", or items 23a or 21412 Great Mills Rd 20653 USA Funeral "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Estimator Electrical Contracting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental is marked c Arden Robinson Loyd Mildred Lorraine Ellis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Scott A. Haselden / Son 38008 W. Edinview Ct. Mechanicsville, MD 20659 permit. Pages 1 and Department of Healt Important: If Item 27 any Injury or other 1 once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) November 16,2007 Ardent Cremations Hanover, MD 22. Name and Address of Facility Ardent Cremations 21. Signature of Funeral Service Licensee Laura C. Hardesty M01197 7522 Connelley Drive Suite A. Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS WEEKS /Medical Due to (or as a consequence of): Examiner LIVER PISEINSE END STAGE LU YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit that the death certificate be executed ALCOHOL CIRICHOSIS HEPATIT15 Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Day Month Vear 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 22 No 1 🗌 Yes 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy perform death? 1 ∐ Yes 2□ No Division or Vital 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient ဥ 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending within 24 hours after death, To the Funeral Director; After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) NOV 2 0 2007

KAVITA SHARMA, THE DOHNS HOPKINS HOSPITAL, 600 N WELFE ST. BALTIMORE, MD U287 32. Registrar's Signature

MEDICAL DOCTOR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NO EMBER 14,2007

DHMH 17 Rev 1/2001

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician San Fort November 12 2007 racu /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Home wood N/A Genesis 8. Date of Birth (Month, Day, Year) 10/6/67 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F 40 Yrs Director 216-84-1746 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anotes. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 DaYes 2 □ No MD N/A Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1918 N. Palyson St. Value of Ever in U.S. 21217 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Armed Forces 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married SpecifiBlack Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Nursing Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ann J. Sanford Lonnie Ray ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1918 N. Payson St.Balt. Ann Sanford/Mother MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balt., MD 11/17/07 Mt. Zion Cem 22. Name and Address of Facility Hari Close F. Svs, P.A. 21. Signature of Funeral 5126 Belair Rd, MD 21206 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) hysician SEPSIS /Medical Due to (or as a consequence of): Examiner MMUNE DEPECINETY STADRING ACOUIRED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed INFECTION 1+ L U Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No ρ Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has e 2 autopsy certificate ha 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier ATTONDING

State

Registrar

30. Name and address of person who co

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2007

31. Date filed (Month, Day, Year)

PHY SICIAN

Momewood

egistrar's Signature

mpleted cause of death (Item 23a) (Type, Print)

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DR MAN NAING CO

NOVEMBER

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Village Parkville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1□M 2XX Days November 22, 1924 Mary I and 82 Yrs Director 212-20-8815 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 □Yes 3√XNo Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t ral", or items 23a or Examiner must be 8800 Walther Blvd 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Who If Yes, Give Year or Dates: "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White Specify þ 3XWidowed 4 ☐ Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephens Ahlers Margaret Ernest injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 seath and 7 is w Charles Kirkland Stark Jr Son |9514GunHill Circle Nottingham Maryland 21236 permit. Pages 1 and Department of Healt Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem Gardens | 11/21/07 Timonium, Maryland 4 Donation 5 D Other (Specify) grature of Funeral Service Licensee 22. Name and Address of Facility John O Mitchell IV Funeral Service of Dulaney Valley PA 200 E Padonia Road
23a. Part1. Enter the disea L, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Dulaney Valley PA 200 E Padonia Road Timonium Maryland 21093 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** end-Stage /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-trar Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 10 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? After t Certification: 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending Injury within 24 hours after deam.

To the Funeral Director: Af investigation 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. Licanse number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bruce Brumentur wether 8-800 W 31. Date filed (Month, Day, Year) 32. Podstrar's Signature NOV 2 0 2007 BELARI Registrar

DHMH 17 Rev 1/2001

		Please Type or Prings State of Ma		Depa	rtment of H	lealth and I	-	_	ole.
7	-	Registrar 1. Decedent's Name (First, Middle, Last)	-	Cer	tificate of	Death	2. Date of Dea	eg. No. 20	0.7 3.7 9.2
Physici /Medic		Anne M. Sicola					Month	Day	Year (3) A M
Examin		4a. Facility Name (If not institution, give street and number) Union Memorial Hospital			4b. City, Town, o	r Location of Deatl		4c. County o	
Funeral		5. Social Security Number 6. Sex 7. Ago	e (In yrs. last b	irthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	1	Birthplace (State or Foreign Country)
Director		141–36–8488 1		Yrs.	World Days	7 Iours Iviiri.	May 19, 1	923	New York
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	or	10a. State 10b. County Maryland N/A	10c. City, Tov		cation				10d. Inside City Limits 1 🛣 Yes 2 □ No
r 28a-f notifie	irect	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Country?
ath with	Funeral Director	1301 Argonne Drive				218		USA	
fter de r items iner m	Fune	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		- American Indian, , White, etc.
ours a	by	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:		1	☐ Yes 2 No	Specify:		Specify:	White
in 72 h "natu ledical	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give I	ent's Usual Occup kind of work done OO NOT use retired	during most of wor	rking	16b. Kind of Bus	siness/Industry
ed with /giene. er thar , the N	Som	Elementary/Secondary (0-12) College (1-4or 5	+)	Са	terer			Own Busir	ness
i be file ntal Hy ed oth	To Be C	17. Father's Name (First, Middle, Last) Joseph Ranone				18. Mother's Name (First, Middle Josephine Bavuso			a)
should and Me s mark umatic		19a. Informant's Name/Relationship (Type. Print)	19			and Number or Ru	ıral Route Numbe		
and 2 lealth a m 27 la		Geraldine Sicola / Daughter				rive Balt			
Pages 1 ent of F nt: If ite ry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemet	ery, crem	sition (Name of natory or other place vice Corp.	i	Date 26/07	Towson M	City or Town, State
ermit. I spartm iportar iy injur		21. Signature of Funeral Service Licensee	THITTE	22.	Name and Addre	ss of Facility	20/0/	TOMPOULL	ai ytailu
20 E # 9		23a. Part 1. Enter the disease, or complications that caused	the death De	53	05 Harford	Roád Bal-			Approximate
Physician		shock, or heart failure. List only one cause on each lir	ne.		- 126		or respiratory arr	est,	Interval Between Onset and Death
/Medical			a consequence	_	ta bolisi	~			One hour
Examiner		Sequentially list conditions, b. Due to (or as.	a consequence	e of):					
executed in and ial-transit	xaminer	if any, leading to immediate Cause. Enter Underthing Cause (Disease or injury that initiated events		,					
0 - 0	ш	resulting in death) Last Due to (or as	a consequence	e of):					
ificate be ex g physician as the burial	edica	d							
ath cert trending or use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		th 3□	Ectopic pregnancy	/		23d. Date	e of delivery
the dea y the at ched fo	ysici	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at 9 ☐ Unknown 9 ☐ Unknown	time of death	5 🗆	Other (specify) _			Wildin	ith Day Year
ss that gned by		Part II. Other significant conditions contributing to death be	-	in the un		h a 6	23e. Did to	bacco use contri	bute to the cause of death?
require een siç hould b	ted l	Endstage rend Disco	52	D:	a heters 1	Mellitis tye	x 2 1□Y	es 2 □ No	3 Probably 4 ♥Unknown
he law e has b ge 2 sh	Completed by	Hypertension					24a. Was a autops perfor	sy pi	Vere autopsy findings available rior to completion of cause of eath?
ian: Ti rtificate tor, pa	Be Co	25. Was case referred to medical				26. Place of Dea	1□ Yes	2 № No 1	Yes 2 No
hysic this ce al direc	10 E	examiner? 1 Yes 2 No Hospital: 1 Impatie				T I INGISING I	lome 5 ☐ Resid		
ding F th. After funera	tion:	27. Manner of Death 28a. Date of Injur 1 ☑ Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation		Time of Injury	28c. İnjur Wor M 1 □	yat k? Yes 2∐No	28d. Describe h	ow injury occurre	ed .
or Atter ter dea irector ⊓ by th∈	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of inju	ury - At home, f c. (Specify)	farm, stre	et, factory, office		28f. Location (S. City or Tow		er or Rural Route Number,
spital o		29a. Certifier 1 ☑ Certifying Physician: To the best of	of my knowledo	ne. death	occurred at the til	me, date and place	and due to the c	ause(s) and mar	oner as stated
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn	edical	(Check only one) 2 Medical Examiner: On the basis of and manner sta	examination a	and/or inv	restigation, in my o	opinion, death occi	urred at the time, o	late and place, a	and due to the cause(s)
To t To tl	ž	29b. Signature and title of certifier			29c. Licens		Ì	_	(Month, Day, Year)
. ~		30. Name and address of person who completed cause of do	Death (Item 220)	(Type f		063163		Jovenber	18,2007
10			eath (item 23a)	, (iype, r	2-16.	. المناه بالد	Park	B.IL	Maryland 21218

State Registrar Stephen Ng vyen , N. D 31. Date filed (Month, Day, Year) NOV 2 0 2007

201 East Vangersity Parkway Bultimore Maryland 21218

Union Mamorial Hospital.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Violet Elizabeth Schlatter November 18, 2007 2:25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 13208 Dulaney Valley Road Glen Arm Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 217 F 302-28-5089 95 **Director** 7/21/1912 Archbold, Ohio Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 10a. State 1 ☐ Yes 2 No Director Maryland Baltimore Glen Arm l0g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be r United States 13208 Dulaney Valley Road 21057 America Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ◯ No White Specify. ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Elementary School 12 should be filed whand Mental Hygiel 7 Is marked other to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic ev John Jacob Spiess Elizabeth Nofzinger ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean S. Kan, M.D./daughter 13208 Dulaney Valley Road Glen Arm, Maryland 21057 20b. Place of Disposition (Name of cemetery, crematory of other place)
Evans Funeral
Chapel—Bel Air Date 20c. Location - City or Town, State 20a. Method of Disposition November 1 ☐ Burial 24 Cremation 3 ☐ Removal from State 20,2009 4 □ Donation 5 □ Other (Specify) Forest Hill, Maryland Peaceful Alternatives Funeral & Cremation Ctr., P. 7 21. Signature of Funeral Service License 2325 York Road Timonium, Maryland 21093 This the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final Shoke **Physician** wee k disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner cerebril Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sels consequence of Examine be executed sician and burial-tran Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐Live birth 3 □Ectopic pregnancy led by the atten detached for u Day 4⊡Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No P.0. 9□Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 27. Manner of Death 1 Matural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending (Month, Day Year) 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com 10 10753 Falls hard #225, Lutherville MD 21092 E MO 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 0 2007 Registrar

DHMH 17 Rev 1/2001

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, been signed by the should be detached page 2

attending physician and for use as the burial-transit certificate this After this funeral of

Physician/Medical Completed by Be Certification: To

29a. Certifier

(Check only one)

edical

Physician

/Medical

Examiner

Funeral

Director

show

?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

Funeral

Completed

Be

Examiner

he Maryland

within 72 hours after

Hygiene.

n and Mental Hygin

permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any injury or other trausonce.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

or Attending Physician; nin 24 hours after death, the Funeral Director: A npletely filled in by the fu he Hospital

To t within To t com	29b. Signature and title of certifier	mo	29c. License number D35102	29d. Date signed (Month, Day, Year)
10	30. Name and address of person who complete	d cause of death (Item 23a) (Type, Print)	lailes Street Ba	HIMOTE MAYYLA
State Registrar	31. Date filed (Mohth, Day, Year)	32 Registrar's Signature	9	

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

atylana Otowan		1- For State Registrar	Certificate o		iu ivientai riygi	Reg. I	No. 200	7 370
Physicia Medical Examin	_	1. Decedent's Name (First, Middle,Last) TATYIANNA A. STEV	<i>I</i> ART			Date of Death Month Da November 12	ay Year 2, 2007	3. Time of Death 0749 hrs
		4a. Facility Name (if not institution, give street and nu Sinai Hospital	mber)	4b. City, Town, o Baltimore	r Location of Death		4c. County of Death	
Funeral Director		5. Social Security Number NONE 6. Sex 1 M 2 F	7. Age (In yrs. last birthday) Yr	If Under 1 Yes Months Day	us House Min	Date of Birth (NOV . 9 , 20	007 9. Bir	
d how any		Usual Residence of Decedent 10a. State MD • 10b. County N/A	10c. City, Town or Loca	ition TIMORE				10d. Inside City Limit
the Maryland on 28a-f show	Director	10e. Street and Number 2227 RUSKIN AVE.		10f. Zip Code 21	217	10g.	Citizen of What Cou USA	ntry?
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Fo	orces? If	Yes, specify Cuba	ispanic Origin? (Specif in, Mexican, Puerto Rica		White, etc.	can Indian, Black,
~ ~	<u>≥</u>	3 Widowed 4 Divorced If Yes, Give Yea or Dates. 15. Decedent's Education (Specify only highest grade Secondary (0-12) College (1 NONE	le completed) 16a. Decede during r	nt's Usual Occupa	o specify: ation (Give kind of work e. DO NOT use retired)		Specify: Sb. Kind of Business/	industry
21215-0036 uld be filed within 72 Mental Hygiene marked other than '	Completed	17. Father's Name (First, Middle, Last) LANCE STEWART SR.	140	NE.	18.Mother's Name (Fig			
p, MD 2121 and 2 should be fi lealth and Mental I lear 27 is marked traumatic event,	To Be	19a. Informant's Name/Relationship (Type, Print) TIFFANY STEWART (mother)	19b. Mailir 2227	ng Address (Stre RUSKIN	TIFFANY I et and Number or Rura AVE. BALTO	l Route Numbe	r, City or Town, State 217	e, Zip Code)
		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal fro 4 Donation 5 Other Specify: 21. Signature of Fundament Service Leading	Gordens	other place)	NOV.19	9,2007		(1)
Balti Bermit. Departo Import injury o		23a. Part T. Enter the disease, or complications that co	1	412 E. P	RESTON ST.	212	13	Approximate Inter
/Medical caminer			nex lained neonat consequence of):	al death				Between Onset a Death
ed	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a	consequence of):					
760, icate be executed physician and the burial - transit	edical	UNPENDED ##54,27 IF FEMALE: 23c. If yes, 4	, perME,g876, 2/1	.4/08 TT				
Box 6876 e death certificat the attending phy ed for use as the	Physician/M	past 12 months?	ant at time of death 5 C	etal death 3 Other (Specify)	Ectopic pregnancy		23d. Date of deliver Month	y Day Year
P.O. B es that the de igned by the be detached is			death but not resulting in the	underlying cause	given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificu within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	Completed by				1.	24a. Was an autopsy performe	prior to	utopsy findings availacompletion of cause
/ital	B B	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 1	npatient 2 FR/Outpatier		Other: Nursing H		sidence 6 Othe	r:
on of \ cading Physath. or: After tl	ition: To	27. Manner of Death 1 X Natural 5 Pending 28a. Date (Month	of Injury 28b. Time of Day, Year)		ury at Work? 286 Yes 2 No	d. Describe hov	v injury occurred	
Division spital or Attendir ours after death. teral Director: A	Certification:	4 Homicide Could not be determined (Specify)	e of Injury - At home, farm, stre	eet, factory, office	building, etc. 28	Location (Stre or Town, Stat	eet and Number or Ri e)	ural Route Number, (
To the Hos within 24 h To the Fun completely	edical	29a. Certifier 1 Certifying Physician: To the bes (Check only one) 2 Medical Examiner: On the basis of and manner s 29b. Signature and title of certifier	of examination and/or investiga	ation, in my opinio		e time, date and	d place, and due to th	ne cause(s)
	2	30. Name and address of person who completed cause	Am, was		OCME .M.E.		9d. Date signed (Mo	-
10 king		Theodore M. King, Jr., MD. Assista	nt Medical Examiner	111 Penn S	treet, Baltimore, I	MD 21201		
Sta Registr	rar	31. Date filed (Month, Day, Year) NOV 2 0 2007 32. R	distrar's Signature	cele				

			Fax	State of	of Marylan	d / Depa	ırtmen	t of H	ealth a	nd M	ental Hyg	giene		
			1 - For State Registrar		•	Cer	tificate	e of D	Death			Reg. No.	007	07000
T			Decedent's Name (First, Middle,	Last)						T	2. Date of Dea	ath C	U U /	3 Time of Death
	Physicia	an	-		m++1		т.,				Month	Day	Year	10:30p ^M
	/Medic	al		<i>A</i> .	Ту	rer	Jr		Location of		Novemb		3 , 2007 inty of Death	10:30P
1	Examin		4a. Facility Name (If not institution,	_						Deali				
		郯	Stella Maris I					OWSO	n If Under 2	M Hre	8. Date of Birt		ltimo	CE lace (State or Foreign
i.	Funeral			6. Sex 1.3XM 2F	7. Age (In yrs.	V	Months	Days	Hours	Min.	(Month, Da	, Year)	Cour	ntry)
	Director		220-68-0177	71	48	3 113.					February	5 , 1959	Mary.	Land
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
	aryla sho d at	'n												1 ☐ Yes 2 X No
	Ba-f	ecto	Maryland Baltim	ore		Dunda]		0.1				10- Citizon	of What Cour	atn/2
	ith th	<u>E</u>	10e. Street and Number				10f. Zip							itry:
	ath v 23a ust	Funeral Director	713 Aldworth Ave					1222					JSA	Indian
	r de	nue	11. Marital Status	Armed F		.S. 13.	Nas Deced If Yes, spec	dent of His cify Cuba	spanic Orig n, Mexican,	jin? (Spe , Puerto	ecity Yes or No Rican, etc.)		Race - Amerio Black, White,	
9	afte or it		1 XNever Married 2 Marrie	If Yes, G			1 □ Yes	2 ⊠ No	Specify:			Spi	ecify: Whi	te
ğ	ours iral", Exa	d by	3 Widowed 4 Divorced	Year or I	Dates:									
2	72 h 'natu dica	Completed	15. Decedent's (Specify only highest	s Education grade completed)	16a. Deced	kind of wo	rk done d	uring most	of worki	ing	16b. Kina c	of Business/In	dustry
2	ithin nan '	ldu	Elementary/Secondary (0-12)	College	(1-4or 5+)		DO NOT us	,						
2	ed w ygier er th	Ş	12 years			Fork	Lift	. Ope	erator				ng Sup	plies
g	a oth	Be	17. Father's Name (First, Middle, L								(First, Middle,	Maiden Sur	name)	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	2	Gordon A. Tyler	Sr.							Schmidt			
a	ges 1 and 2 should nt of Health and Men If Item 27 is marke or other traumatic		19a. Informant's Name/Relationshi	p (Type. Print)							al Route Numb			Code)
≥	1 and 2 Health tem 27		Lillian Tyler	m	other						undalk,			222
Se	es 1 of He roth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Pomoval from		Place of Dispo cemetery, crea	matory or c	ther place			mber		on - City or To	
altimore,	permit. Pages 1 Department of H Important: If Itel any Injury or ott		4 □ Donation 5 □ Other (Sp		Gar	dens of	Faith	Cerret	ery 2	3, 2	007	Roseda	ale, Ma	aryland
ä	mit.		21. Signature of Fymeral Service L	icepsee)	00	22	2. Name an	d Addres	s of Facility	/	ne Of D	11	- D 7	
m	Der any any any		(Inthony	Con	nelli	1 71	nne II	yru	nerai	nt l	Road, D	undalk undalk	Md 2	1222
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that	caused the deat	h. Do not ent	er the mod	le of dyin	g, such as o	cardiac (or respiratory a	rrest,		Approximate Interval Between
	Dhualalan		Immediate Cause (Final											Onset and Death
)	Physician /Medical		disease or condition resulting in death)		ER DISEA o (or as a conseq				_					
	Examiner		1	Due	o (or as a conseq	judinico orj.								
1		ā	Sequentially list conditions,	b. — Due tr	o (or as a conseq	uence of):								
7	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
	xecu and	xar	that initiated events resulting in death) Last	cDue to	o (or as a conseq	uence of):								
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit			L										
	phys phys the	dical		d										
9 ×	leath certific attending p	/Me	IF FEMALE:	23c If yes o	utcome pf pregna	ancv						234	. Date of deliv	en/
8	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	e birth 2□Feta gnant at time of o	al death 3	Ectopic p					200	Month	Day Year
o.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unk		Jean JL	_ Other (at	Jecny)						
<u>.</u>	that the dened by the a	Physician/Me	Part II. Other significant condition	ns contributing to	death but not res	ulting in the u	nderlying c	ause give	en in Part I.	-	23e. Did	obacco use	contribute to	he cause of death?
Vital Records, P.O. Box	res tha signed be del	by	. a. m. out of organization	g		g	,				10	Yes 2□N	lo 3□Pro	bably 4X Unknown
O.C	w requir been si should	Completed		-										
ec	law as b	ple									24a. Was auto	psy	prior to co	opsy findings available ompletion of cause of
<u>~</u>	The ate h page	TO.									perfe 1⊟ Yes	ormed? 2 X No	death? 1 ∐ Yes	2 No
Ħ	sician: The law certificate has t irector, page 2 s	Be (25. Was case referred to medical examiner?						26. Place	of Deat	h (Check only	one)		
2	nysic lis ce direc	To E	1 Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 🗆 D0	OA Othe	er: 4 🗆 Nui	rsing Ho	me 5 Res	dence 6X	Other (Spec	fy) HOSPICE
Division or	ng Pt tter th		27. Manner of Death 1 Natural 5 □ Pending	/8.4-	e of Injury onth, Day Year)	28b. Time of Injury	f 2	28c. Injun Work	y at k?		28d. Describe	how injury o	ccurred	
0	ath.	atic	2 ☐ Accident investiga	ation			М	1 🗆 '	Yes 2□N	No				
<u> </u>	er de recte by th	ific	3 Suicide 6 Could n 4 Homicide determin	ned Zoe. Flat	ce of injury - At h Iding, etc. (Speci	ome, farm, st	reet, factor	y, office				Street and N wn, State)	lumber or Rui	al Route Number,
ō	s afte	Certification:				-77								
	hour hour nera ly fille		29a. Certifier 1X CertifyIng (Check only 2 Medical E	g Physician: To the Examiner: On the	he best of my kno	owledge, deal	h occurred	at the tin	ne, date an	d place,	and due to the	cause(s) an	d manner as	stated.
	n 24 ne Fu	Medical	one)		anner stated.	alion and/or ii		i, iii iiiy 0	pinion, dea	ilii occui	red at the time	, uate and pr	acc, and duc	
	To the Hospital or Attending Physician: within 24 hours after cleath. To the Funeral Director: After this certifica completely filled in by the funeral director,	M	29b. Signature and title of certifier)			29		e number			29d. Date s	igned (Month	, Day, Year)
			-	-				1	137	21		11	119107)
•	_		30. Name and address of person v	who completed ca	use of death (Iter	m 23a) (Type,	Print)						1 [
	1		DR. TARIO MAHMO		DULANEY			т	MONTI	JM.	MD 2109	3		
	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Sign	ature								
	Regist		NOVE	2007	A Comment	K d	ogsk	9						

DHMH 17 Rev 1/2001

NOVEMBER 18, 2007 10:30 p.m.

GORDON TYLER

executed P.O. Box 68760, death certificate be Division or Vital Records, or Attending Physician:

and burial-tra the attending physician as the use Por detached signed by the peen has page 2 this certificate Certification: After

items 23a

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"natural",

than

Is marked other

item 27 l

Pages 1 permit. Pages 1 Department of H Important: If ite

2 should be filed within and Mental Hygiene.

72 hours after

Saltimore, Maryland 21215-0036

To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

loshua State Registrar MOY 2 0

4 Homicide

(Check only one)

29a. Certifier

Medical

29c. License number 1225246077

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ne and address of rsor who completed cause of death (Item 23a) (Type, Print) MOSKOVITZ

Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

N. Greene Street BALtimore, Md

31. Date filed (Month, Day, Year)

29b. Signature and the of certifier

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Carolina Tipton Nov. 13 2007 8:08PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 152 West Chestnut Hill Baltimore Reisterstown 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 😿 F 88 415-12-6363 July 25, 1919 NC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 🕱 No Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 152 West Chestnut Hill 21136 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Western Electric Factory Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alex Lewis Winnie Hensley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 152 West Chestnut Hill, Reisterstown, MD 21136 Ban Marie Schatz Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Cemetery 11-17-07 Erwin, TN 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cau, on each line. 23a. Part1. Enter the disea shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARD 30 MIN disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show a or 28a-f sh t be notified

ms 23a

the Medical Examiner

or items

"natural"

of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me

of Health a

= 5 Department of Important: If any Injury or once, Funeral Director

Completed by

Be

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MD

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Physician/Medical by Completed Certification: To Be Medical

or Attending Physician: The law requires that the death certificate be executed

à

this

After

the

s after death. death.

within 24 hours a Hospital

the

Division or Vital Records, P.O. Box 68760,

for use as the burial-tra funeral director, page 2 should be filled in by

IF FEMALE: 23b. Was decedent pregnant in the past 12 mont 1 Yes 2 No

autopsy performed 1∐ Yes 2 2 No Were autopsy findings available prior to completion of cause of death? 1 □Yes 2□ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 🔲 Yes 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 5 ☐ Residence 6 ☐ Other (Specify)

27. Mann of Death 1 Unatural 2 Accident

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

(Check only one)

5 Pendina investigation Could not be determined 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 TYes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified

29c. License number

29d, Date signed (Month, Dav. Year)

Name and add

ess of person who completed cause of death (Item 23a) (Type, Print) HIRAN 31. Date filed (Month) Registrer's Signatur 32.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** C. Tallarico Doris V07/emper 18 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner dale Mare 0 05 If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1922 Baltimore City, MD 1 □ M 2 □ F 217 24 9639 December 84 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore County 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21206 USA 4603 Kenwood Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black White etc. 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married リの下に *| タルのドレの* ttimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify. þ 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 8 N/A Accounting Clerk Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christian Hudson George Schmidt ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8958 Park Street Red Lion, PA 17356 Joyce C Vaughn 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Gardens of Faith Cem. November 21 2007 Baltimore, Maryland 21 So at re of Funeral Service Lic-22. Name and Address of Facility
Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical Examiner Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the conditions, and the conditions of the conditions, if the conditions is a condition of the conditions of the Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. | as been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No has page within 24 hours after death.

To the Funeral Director: After this completely filled in Exercises. certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending investigation (Month, Day Year) Iniun 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mysico: a

State Registrar

DHMH 17 Rev 1/2001

edicent

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Franklin

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

000

Ste

NOV 2 0 2007

aura 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary Anne Timmerman Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Severna Park Center Severna Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 93 Director 215-05-7479 Oct. 26,1914 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at **Funeral Directon** Maryland Anne Arundel Annapolis 10q. Citizen of What Country? 10f. Zip Code 10e. Street and Number 85 Manresa Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married

College (1-4or 5+)

worn

1 ☐ Yes 2 No

Hostess

20b. Place of Disposition (Name of cemetery, crematory or other place)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

a I Inknown

4☐Pregnant at time of death

Hizheimen

Belair Memorial Cardens

3 Ectopic pregnancy

28c. Injury at Work?

1 👺 sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

5 Other (specify)

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Specify

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Anna Gumbert

22. Name and Address of FacilityMitchell-Wiedefeld F.H. Inc.

6500 York Road Baltimore, Maryland 21212

24a. Was an autopsy

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

D32036 11/14/2

26. Place of Death (Check only one,

1☐ Yes 2☐XNo

28d. Describe how injury occurred

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11-16-07

484 Lymington Road Severna Park, Maryland 21146

Day

13

2007

Anne Arundel

Maryland

14. Race - American Indian

Black White etc.

Specify: White

Funeral Service

16b. Kind of Business/Industry

Belair, Maryland

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of

2 No

Year

Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

death? 1 ☐ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

4c. County of Death

U.S.A.

6:00 p.

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 X No

Birthplace (State or Foreign Country)

altimore, Maryland 21215-0036 Department of Health a important: if item 27 is any injury or other trau **Physician** /Medical

Completed by

Be

P

Physician/Medical Examine

Completed by

Be

Certification: To

Medical

IF FEMALE:

3 XWidowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Henry George Mohr

Robert J. Timmerman

4 Donation 5 Other (Specify)

21. Signature of Funeral Service Vicense

19a. Informant's Name/Relationship (Type. Print)

12

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 THomicide

(Check only one)

29b. Signature and title of certifie

15. Decedent's Education (Specify only highest grade completed)

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

Examiner

The law requires that the death certificate be executed burial-transit the. attending ph ate has been signed by the page 2 should be detached certificate Hospital or Attending Physician: director, this funeral After t 24 hours after death. filled in by the within 24 hor To the Fune completely fi the

Division or Vital Records, P.O. Box 68760, 🕰

4

State Registrar

DHMH 17 Rev 1/2001

O. Down 2108 31. Date filed (Month, Day, Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12, **Physician** 2007 Vogel November Helen /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 4213 Ritchie Hgwy. Brooklyn Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Days Maryland 1 M 2 F Months Hours 85 Director 212-30-6587 Usual Residence of Decedent July 27 1922 the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Anne Arundel Co Brooklyn Park Md. permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If then 27 is marked other than "nature" any Injury or other traumatin memory. 10e. Street and Number 10g. Citizen of What Country? 21225 U.S.A. 4213 Ritchie Hgwy Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No White Completed by 3 ₩idowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Secretary 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phillips Doloris Gehring John ပို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4213 Ritchie Hgwy. Baltimore, Md. 21225 <u> Helen Albiker (daughter)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) St Paul Cemeterv 11/16/07 Violetville, Md. 22. Name and Address of Facility Conce Funeral Service PA 21. Signature of Funeral Service Licenses 4001 Ritchie Hgwy. Balto. Md. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician neu monu /Medical Due to (or as a consequence of) Examiner 44 Sequentially list conditions, any sequentially limited access. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical SS IF FEMALE: yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has le 2 certificate ha autopsy perform 2 0 No or Attending Physician; director, 25. Was case referred to-medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 🔲 inpatient 2 ER/Outpatient 3 DOA this 27. Manner Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Datural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: / 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

within 24 hours are To the Funeral Dir Hospital

State Registrar

CAASOU LO 31. Date filed (Month, Day, Year) NOV 2 0 2007

29b. Signature and title of sertifier

30. Name and address

29a. Certifier (Check only one)



person who completed cause of death (Item 23a) (Type, Print)

1 🗲 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 10=18 AM Mary white November 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City, Town, or Location of Death Examiner Johns Hapkins Bayriew Medical Center Rattimoro 8. Date of Birth (Month, Day, Year) Sept. 18, If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign 1930 Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 217 F Sept. 77 Director 228-32-5634 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2□No Director Virginia Westmoreland Montross 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 22520 571 Grainery Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify Specify: 2 3℃ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event. White Packing Co. Elementary/Secondary (0-12) College (1-4or 5+) 9th grade Meat Packer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Georgianna Herbert Brooks ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 Streamside Drive Mitchellville,Md 20721 Delilah White /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 11/24/07 Montross, Virginia Family Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Ho 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service Licen arrio 3a. Pay. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, suck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician Respiratory Failure 1 hour disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner weeks Relmonary Lymphanatte Sequentially list conditions, if any, learning to min sorate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nunsectionce of) Examiner months be executed Metastatic Execus burial-tran and Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical the as 1 IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ yes 2 ☐ No ρ Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9□Unknown 9 Unknown cate has been signed by the page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ #fiknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed certificate 1∐ Yes 2□ No 2 - No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No 2 ER/Outpatient 3 DOA ۹ this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural Injury To the Hospital or Attendil within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

4940 Eastern

32. Reģištrar's Signature

Marie Spiles

Avenue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

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31. Date filed (Month, Day, Year)

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Buttimore, MD

Nivember 14 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle J ast) 4b. City, Town, or Location of Death 4c. County of Death Name (If not institution, give street and number, BALTIMORE HOS N/A 8. Date of Birth (Month, Day, Year) May 2,1924 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number Davs Hours Months 1 M 2□ F Maryland 83 219-16-3091 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Towson Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Starbit Road 21286 USA 936 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □X*es 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√√No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lumber Company Quality Controller 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Strickland Edna Herbert Wagner, Sr. Bessie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Towson, Maryland 21286 Metta L. Wagner / Wife 936 Starbit Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Marial 2 ☐ Cremation 3 Removal from State Druid Ridge Cemetery 11/20/07 Pikesville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 1050 York Road 21. Signature of Fundral Service License Ruck Towson Funeral Home, Inc.Towson,Md.21204 - On that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of shock, or heart failure. Lis only one ca Immediate Cause (Final disease or condition disease or condition resulting in death) ischemic Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Due to (or as a consequence of):

Physician: The law requires that the death certificate be executed and burial-trai Division or Vital Records, P.O. Box 68760, attending physician as the for use signed by the a page 2 s certificate has director. this After To the Hospital or Attending n 24 hours after death. he Funeral Director: A pletely filled in by the fu

Physician /Medical

Examiner

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

Be Completed by

Certification: To

Medical

29b. Sign

Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 ☐Ectopic preg			23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resultin	g in the underlying cau	se given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
				24a. Was an autopsy performed'	
25. Was case referred to medical			26. Place of Dea	th Check onl one	
examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2 ER	Outpatient 3 DOA	Other: 4 Nursing H	ome 5 Residence	6 □Other (Specify)
27. Man of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	b. Time of lnjury M	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred
3 ☐ Suicide 6 ☐ Could not be determined		, farm, street, factory, o	office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	miner: On the best of my knowle and manner stated.	dge, death occurred at and/or investigation, in	the time, date and place n my opinion, death occu	e, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

State Registrar

the

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31. Date filed (Month, Day, Year) NOV 2 0 2007

who completed cause of death (Item 23a) (Type, Print) RNON 560 | Loch Raven Blvd Balhmore MD SALMON 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Wushington **Physician** 4:320 M VIMES 164mber, 18,2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Hospita] Bon Secours If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1**∑**M 2□ F Yrs. 49 30 58 MD 220-64-8168 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ¥Yes 2 No Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21217 1917 Riggs Ave Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black <u>Ş</u> 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Home Improvements 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Commodore ၉ Thomas Washington Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i 21215 Sunset Road, Baltimore, Md 5101 Jami Washington-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any Injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion 11/24/07 Baltimore, Md 22. Name and Address of Facility ature of Funeral Service Licensee 28a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, humediate Cause (Final disease or complications). March F/h West 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death I amedia e Cause (Final disease or condition resulting in death) Siptic Shock **Physician** /Medical Due to (r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, Uncease or nighty that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? ate has been signed page 2 should be det Be Completed by ENO Stag asease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Dommunode autopsy 2 XNo certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State

29b. Signature and

3 Date filed (Month

address

Name an

Registrar

fospital

of person who completed cause of death (Item 23a) (Type, Print)

Secours

32. Redistrar's Signature

29c. License number

2000 Wist Baltimore STreet

29d. Date signed (Month, Day, Year)

Bultimore Hayland 21223

	•	For State Registrar	State of N	Maryland / (irtment of tificate of		nd Menta	l Hygien	211111	37105		
Physicia		Decedent's Name (First, Middle, Last)				2. Date of Month			nth D	Death Day Year ber 2, 2007 O300km			
/Medic Examin		Julia St. Clair Webb 4a. Facility Name (If not institution, give street and number)				4b. City, Town,	or Location of			c. County of Deat			
		21190 Poplar 6	Grove Lane			Avent	ıe			St. Mary	S		
Funeral Director		5. Social Security Number 579–26–5999	6. Sex 1 □ M 2 ☐ F	Age (In yrs. last bii 80	rthday) Yrs.	If Under 1 Yea Months Day		Min. (Mor	of Birth orth, Day, Year 5 , 19	r) Co	hplace (State or Foreign nuntry) nington DC		
and		Usual Residence of Decedent 10a, State 10b. County		10c. City, Tow	m or Lo	cation					10d. Inside City Limits		
Maryl f eho	ō		Mary's	Aven							1 ☐ Yes 2√ No		
r 28a	rec	10e. Street and Number		121011		10f. Zip Code			10g. C	itizen of What Co	untry?		
th with	alD	21190 Poplar G	rove Lane			20	604			USA			
permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "naturel; or Iteme 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be multiled at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marr 3 ☒ Widowed 4 □ Divorced	If Yes, Give 2	s? ₹No	l li	Vas Decedent of Yes, specify Cu □ Yes 2∑ No	ban, Mexican,	in? (Specify Yes Puerto Rican, e	or No-	14. Race - Ame Black, Whit Specify: Wh	e, etc.		
turei	ed L	15. Decedent	Year or Dates		Deced	ent's Usual Occi	ination		16h	Kind of Business			
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giene grene er the	E	12	O College (1-40	5+)	С	ashier			gr	ocery st	ore		
be file tat Hy d oth	Be (17. Father's Name (First, Middle,	Last)				18. Mother	's Name (First, I	Middle, Maide	n Sumame)			
Mend I Mend I Merken Merken	ဂ္	William Augus						y Louis					
12 sh h and 7 ie m treum		19a. Informant's Name/Relations Warren Webb/s								or Town, State, 2	Zip Code)		
Healthern 2	1	20a. Method of Disposition				Thomas	Court	Avenue,		0609 Location - City or	Tourn State		
Pages tment of tant: If it		1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (S)	pecify)	comoto	ry, cren	natory or other pl							
Departing Important Import		21. Signal III. of Euneral Service Ronal Control	Usuc		Ba	1timore	, MD 2	1201		1timore	Street		
Physician	4	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition as Conceptor the mode of the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death Cause (Final disease or condition as Conceptor the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death Cause (Final disease).											
/Medical Examiner	er	Due to (of as a consequence of): Due to (of as a consequence of):								Dyears			
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ficate p phys	edicai		d										
To the Hoepital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter deeth. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify)								23d. Date of delivery Month Day Year			
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equires en sign ould be	ted by								1 ☐ Yes 2 ♣ No 3 ☐ Probably 4 ☐ Unknown				
hysician: The law r nis certificete hes be I director, page 2 sh	Completed	2007 [2]						_	. Was an autopsy performed?	prior to	Itopsy findings available completion of cause of 2 □ No		
lcian certifi ector	Be	25. Was case referred to medical examiner? 26. Place of Death (Check only one)											
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To the Hoepital or Attending F within 24 hours efter deeth. To the Funeral Director: After completely filled in by the funer.	Medical (29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
To th To th comp	M	29b. Signature and title of certifier	1	/_ ;	111) 29c. Licer	ise number		29d. D	ate signed (Mont	h, Day, Year)		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leon W. Berube, M.D 78170 Old Village Rd., Mechan.cs 31. Data filled (Month Day Year)							11	11/12/07			
		30. Name and address of person	who completed cause of	death (Item 23a)	(Type, I	Print)	e i na	hance	111-	011 321	~~G		
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Registra		NOV 2 0 20	07 Asset	strar's Signature	SEA								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

07-08813								
Larry	Wolf							

arry Wolf	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Per No. 2007 3710									
Physician	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death									
Medical Examine	Larry Wolf November 13, 2007 1115 hrs									
X)	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel									
Funeral Director	5. Social Security Number 217-23-1782 1 M 2 F 33 Yrs. 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD									
, i	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits									
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ith the Maryland 23a or 28a-f show notified at once. al Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?									
the Manuel Manue	407 Burbank Court 21227 USA									
or death with the Maryland or items 23a or 28a-f sh must be notified at one Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.									
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215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once Be Completed by Funeral Director	12 N/A Route Sales Herr's Potato Chir 17. Father's Name (First, Middle, Last)									
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Larry A. Wolf, Sr. Betty Farmer									
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imore, MD 2 Pages I and 2 shou rent of Health and hiant: If item 27 is n or other traumatic	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State									
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Baltimore, permit. Pages I am Department of Heal Important: If iten injury or other tra	21. Signature of Funda Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA									
Physician	1201 Dundalk Avenue Baltimore, MD 21222 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval									
/Medical	failure. List only one cause on each line. Between Onset and Death									
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Box 6876 death certificate the attending phy ed for use as the thy sician/M	past 12 months? 1									
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u completed by Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?									
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of Vital Records, P g Physician: The law requires t then this certificate has been sign neral director, page 2 should be d T. To Be Completed b	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of									
Reco	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No									
of Vital Recting Physician: The After this certificate funeral director, page on: To Be Con	25. Was case referred to medical examiner? 26.Place of Death (Check only one)									
of Vi Physi ter this eral dir	1 Ves 2 No 139 Date of Injury 28h Time of Injury 138 Injury of Mark? 128h Describe how injury occurred									
	27. Manner of Death 1 Natural 5 Pending A Date of Injury Nov 13, 2007 A Natural 5 Pending Nov 13, 2007 A Natural 5 Pending Nov 13, 2007 A Natural 5 Pending A Natural 5 Pe									
Division al or Attendii as after death. al Director: A led in by the fi	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
E 0 5 € 1 C)	4 Homicide determined (Specify) Liquor Store 100 Defense Highway, Annapolis, MD									
To the Hos within 24 h To the Fun completely	(Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
To To To com	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
	O.C.M.E. November 14, 2007									
1041	30. Name and address of person who completed cause of death (Item 23a)									
	Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed Mark Day, Year) 2007 32 Registrar's Signature									
State Registra										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Charles Weigert 1. For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day Year November 18, 2007 1153 hrs Medical Examiner Charles Weigert 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Bayview Medical Center 8. Date of Birth (MMDD/YYYY) 9. Birthplace (State or More 2 107.7 Foreign Mary Land 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex **Funeral** Months Days Hours Director 60 Mar2,1947 215-46-7219 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location iny 1 X Yes 2 No 28a-f show Baltimore with the Maryland Md Director 10g. Citizen of What Country? 10e. Street and Number 3407 East Lombard Street 21224 U.S.A. must be noti 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. death 1 Never Married 2 Married Yes Specify: White Yes 2X No specify: 3 X Widowed Divorce If Yes Give Year Baltimore, MD 21215-0036
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Important: If item 27 is marked other than "natural",
injury or other traumatic event, the Medical Examiner <u>۾</u> 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th Delivery Man Delivery 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eileen Davis Charles Francis Weigert, Sr. Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1967 Ewald Ave. Baltimore, Md. Charleen Riggs 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Bayview Crematory 11-20-07 Baltimore, Maryland Donation 5 Other Specify: 22. Name and Address of Facility aczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses 1201 Dundalk Ave. Baltimore. Md. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line M dical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease :aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical tending physician a use as the burial - t UNPENDED AMENDED e Hospital or Attending Physician: The law requires that the death certificate be e 2.24 hours after death.
Purpose a Pinner after After this certificate has been signed by the attending physicial per littled in by the funeral director, page 2 should be detached for use as the burial tenely filled in by the funeral director, page 2 should be detached for use as the burial. P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Dav Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 V Unknown Chronic Obstructive Pulmonary Disease; Chronic Alcoholism Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? Yes 2 No 1 V Yes No 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: Hospital: 1 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 🗸 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 1 V Natural 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the F and manner stated Signature and title of ceptifier 29c, License number 29d. Date signed (Month, Day, Year) November 19, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registra

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31. Date filed (Month, Day, Year)

32 Registrar's Signature

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			Registrar 1. Decedent's Name (First, Middle, La.	Certificate of Death					2. Date of Death 3. Time of Death					
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	/Medic		4a. Facility Name (If not institution, give			VYC	4b. City, Town, or	Location of D		CHUC.	4c. County		10.55 F	
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	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If tier 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ita Madical Evaria and mission collies at an once.	Funeral Director	85 Hospital Rd.				20678				Unite	United States		
		ner	11. Marital Status 12. Was Decedent E- Armed Forces?			S. 13.	Was Decedent of Hi f Yes, specify Cuba	? (Specify Ye	es or No-		14. Race - American Indian, Black, White, etc.			
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Baltimore,	nit. Partme ortan injury		21. Signature of Funeral Service Lices		DC.	-	-							
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			21. Signature of Funeral Service Licensee 22. Name and Address, of Facility Mitchell—Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23. Name and Address, of Facility Mitchell—Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 24. Name and Address, of Facility Mitchell—Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212											
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):											
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	ttend death ttor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	98 Place of Inju	M 1 Yes 2 No					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
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	Sta	to:	Peter Wisniewski 31. Date filed (Month; Day, Year)	, M.D. 82		spital	ru. Pri	nce Fr	ederic	K, 1	D 2007	0		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Physician Lawrence Charles Winder November 16, 2007 5:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1127 Silver Leaf Drive Arnold Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 217 52 2716 58 Director May 6. 1949 Marvland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1127 Silver Leaf Drive 21012 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Construction Steel Foreman L.R. Willson & Sons Inc. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked o any injury or other traumaticans. Elwood M. Winder Catherine Teal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Winder / Wife 1127 Silver Leaf Drive Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Park 11/20/2007 Glen Burnie, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A momerour 4001 <u>Ritchie Highway</u> Baltimore, Maryland 21225 23a. Pari1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ancveanc canceir ZYVI YMOS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in module cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to (or as a nonsequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 1 Yes 2√2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

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To the Hospital or Attending within 24 hours after death.

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72 hours after

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Maryland 21215-0036

Baltimore,

Box 68760,

Division or Vital Records, P.O.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Medical

4 Thomicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

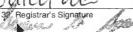
| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

of death (Item 23a) (Type, Brint) O Bestgate Rd. Annapolis, und. 30. Name and address of person who comp

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0072. Date of Death 1. Decedent's Name (First, Middle, Last) Day 13:1 | HELLES WATKINS 18 2007 NOVEMBER CLAUDE 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE HARBOR HOSPITAL 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours 1 X M 2 □ F 80 June 9, 1927 North Carolina 243 36 2596 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 XNo Baltimore Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21225 U.S.A. 113 - 15th Avenue Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: Korean 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemical Company Laborer 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vance Watkins Irene Grogan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 Noreen Stump / Daughter 113 - 15th Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park: 11/21/2007 Glen Burnie, Maryland ^{22. Name and Address of Facility} Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Danerou ana mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, any one cause on each line. 214. Part I. Enter the diseas , 10 shock, or heart failure List Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 09 HOURS GASTRO-INTESTINAL HEMORRHAGE Due to (or as a consequence of): 05 DAYS DIVERTICULAR DISEASE Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

Examiner

Director

Funeral

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within 72 hours after death with

Baltimore, Maryland 21215-0036

Box 68760.

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Division or Vital Records,

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Examine Physician/Medical Completed

physician and the burial-transit as 1 signed by the attending I peen s certificate has t lirector, page 2 s

After this c funeral dire

certificate be The law requires that or Attending Physician: To the Hospital or new within 24 hours after death.

To the Funeral Director: Aft

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Certification:

Medical

☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ▼ Yes 2 No 3 Probably 4 Unknown RESPIRATORY AND METABOLIC ACIDOSIS 24b. Were autopsy findings available prior to completion of cause of 24a. Was an CHRONIC OBSTRUCTIVE PULMONARY autopsy performed death? 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

diccom MD

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NOVEMBER IS 2007

2□ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 SOUTH HANWER STREET, BALTIMORE, MARYLAND 21225 A DEMUNLE OBISESAN, MD

State Registrar

31. Date filed (Month, Day, Year) 2007



XI

parts 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 05PM 2007 HITE Nox /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ERCU 10SPITAL N/A UNTORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 10–30–1959 9. Birthplace (State or Foreign **Funeral** Months 1√2 M 2 □ F Days MARY LAND 48 219-80-7283 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "instural", or Items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director N/A MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3615 W. LEXINGTON ST. 21229 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ KNo Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12**-**COMPUTER TECHNICAN DEPT. OF JUSTICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CALVIN WHITE EUNICE BYRD ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EUNICE WHITE (MOTHER) 3615 W. LEXINGTON ST. BALTIMORE, MARYLAND 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 □Removal from State KING MEMORIAL PARK 11-23-2007 BALTIMORE, MARYLAND 4 Donation 5 D Other (Specify) 21. Signature of European Service Lichnsee JONATHAN HIBNER Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. P rt1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme tiate Cause (Final disease of condition resulting in death) Physician NEUMOCYSHS /Medical Due to (or as a consequen of): Examiner 115 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to for as a consequence off Examiner be executed burial-transi and Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>ک</u> 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Hospital or Attendl 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 42634 0561 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL (>LACE BACTIMORE, MD COSTA 301 05 EPT 32. Signature 31. Date filed (Month, Day, Year) State NOV 2 0 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15, Physician Thelma Betty Zurawski November 2007 6:10a /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 348 Bigley Avenue Lansdowne Baltimore 5. Social Security Number If Under 1 Year | if Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y)
Jan. 22, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F Year Months Days Hours 215-30-2206 72 1935 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show r 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Baltimore Lansdowne 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or LExaminer must be r 348 Bigley Avenue 21227 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify Completed by 3 X Widowed 4 □ Divorced Year or Dates: item 27 Is marked other than "naturation" other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home unknown Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Dewy Emma V. Folkes 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johanna Greenway/Daughter <u>348 Bigley Avenue Lansdowne MD 21227</u> altimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If ite any injury or ot West Arundel Crematory 11-19-2007 Odenton, Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227 23a. Part1. Enter the disease, of complications that caused the death on not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PULMONARY Immediate Cause (Final CHRONIC OBSRUCTIVE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the cause). Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician by Physician/Medical IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No detached the 9□Unknown MA. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? DISOR DER 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 autopsy performed? Yes 25 No this certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Julka 1200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. EUTAWST. SUITE 407 MB SURJIT S. JULKA MD 31. Date filed (Month, Day, Year) NOV 2 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Physician /Medical certificate be executed Division or Vital Records, P.O. Box 68760 or Attending

Examiner sician and burial-tran attending physician the as use Por detached f page 2 certificate After pletely filled in by the

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

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Funeral

Director

show

jiene. r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at

within 72 hours after

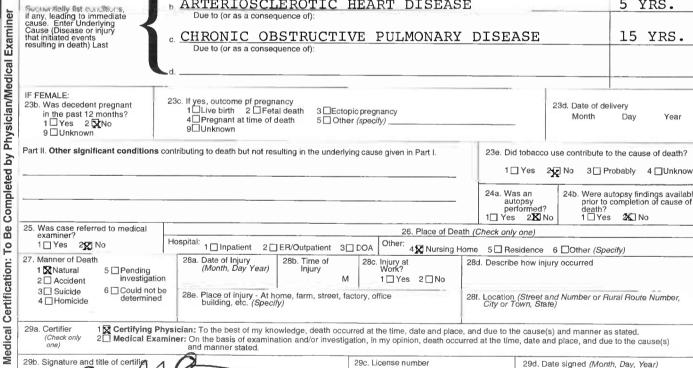
permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other trainmasts.

Baltimore, Maryland 21215-0036

Physician/Medical Completed Be 2 Certification:

death. after death To the Hospital or within 24 hours at To the Funeral E

> State Registrar



Belair Rd.

D001728

November 13, 2007

Baltimore, Maryland 21236

M.D.

8022

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Yin Oung,

NOV 2 0

31. Date filed (Month, Day, Year)

			State of Maryland / Department	artment of Health and M Artificate of Death	lental Hygiene Reg. NO 7 37 14
	Physicia	_	1. Decedent's Name (First, Middle, Last) Martin Harrison Blank		2. Date of Death November 13, 2007 7:54 AM M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number) 113 East Church Street	4b. City, Town, or Location of Death Frederick	4c. County of Death Frederick
	Funeral Director		5. Social Security Number 214-46-7399 6. Sex 12 F 7. Age (In yrs. last birthday) $12 \text{ M} 2 \text$	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 31, 1947 8. Birthplace (State or Foreign Country) Maryland
2,	show ed at	or.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Maryland Frederick Frederick		10d. Inside City Limits 1 ሺ Yes 2 □ No
	with the N 3a or 28a-f t be notiffi	Funeral Director	10e. Street and Number 113 East Church Street	10f. Zip Code 21701	10g. Citizen of What Country? U.S.A.
200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at one.	by Funera	4 The standard Officerial WTVoc 2 Table CE 107/	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
N-C 17	vithin 72 hou ne. han "natura Medical E	Completed		dent's Usual Occupation kind of work done during most of work DO NOT use retired) d and Operated	ing 16b. Kind of Business/Industry Flower Shop
שוות ל	id be filed w ental Hygie ked other ti ic event, th	To Be Co	17. Father's Name (First, Middle, Last) Meredith Leo Blank, Sr.	18. Mother's Name	e (First, Middle, Maiden Surname) te Raye Draper
Wary	and 2 shou alth and M 27 is mar er traumati	-		Belgrave Circle,	ral Route Number, City or Town, State, Zip Code) Frederick, MD 21704
paltimore,	Pages 1 ament of He ant: If item ury or othe		4 Donation 5 Other (Specify)	rg Crematory Nov.	
סמור	permit. Departimont amy inj		morange with	106 East Church St	d PA Funeral Home ., Frederick, MD 21701
	Physician /Medical Examiner		resulting in death) Due to (or as a consequence of):	Artery Disease	or respiratory arrest, Approximate Interval Between Onset and Death 5 years
. ,00/9	certificate be executed ding physician and se as the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
O. BOX 68	death certific e attending p d for use as	Physician/Medi		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
rds, P	requires that the een signed by th hould be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1XXYes 2 □ No 3 □ Probably 4 □ Unknown
II Kecords,	The lar	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 ⚠ Yo 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No
or Vital	hysician: this certifical	To Be	25. Was case referred to medical examiner? 1 Yes ZW No 27. Manner of Death 28a. Date of Injury 28b. Time	ent 3 DOA Other: 4 Nursing H	th Check onl_one ome 5\tilde{\sqrt{T}}\text{Residence} 6 □ Other (Specify) 28d. Describe how injury occurred
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	Certification:	27. Manner of Death XX Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 28b. Time (Month, Day Year) 28c. Place of injury - At home, farm, so building, etc. (Specify)	Work? M 1 ☐ Yes 2 ☐ No	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	ie Hospital 24 hours ie Funeral	Medical C	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, dear of the basis of examination and/or and manner stated.	ath occurred at the time, date and place nvestigation, in my opinion, death occu	urred at the time, date and place, and due to the cause(s)
)	To th withir To th	Me	29b. Signature and title of certifier The Utaulto MA	29c. License number D 27544	November 13, 2007
	12			O Thomas Johnson I	Drive, #202 Frederick, MD 21702
JA.	St Regist	ate trar	31. Date filed (Month, Day, Year) NOV 2 0 2007 32. Registrar's Signature	barli	

			For State Registrar	State of Man		artment of F		Mental Hygie	2001	37115
I	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
3	/Medic	al	Edward Joseph Bleie 4a. Facility Name (If not institution, give s			4b. City. Town, o	r Location of Deat	10/26/	4c. County of Death	9:30am M
	Examin	-	Anne Arundel Medica			Annapo1			Anne Arun	
	Funeral Director		5. Social Security Number 6. Sex 226-84-7088	7. Age (/	n yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign intro) ermany
	the Maryland 28a-f show notilities at	rector	Usual Residence of Decedent 10a. State MD 10b. County Anne Ar 10e. Street and Number	undel	Oc. City, Town or Lo Shady S:			100	. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2√√No
	h with	i Di	4949 Bonnie Wood Dr	•			20764		USA	,
9036	should be filed within 72 hours after deeth with the Maryland of Mental Hygiene. marked other than "naturel", or iteme 23a or 28a-f show marked other than "naturel", or iteme 23a or 28a-f show marked other than Mudical Examiliner, has be notified at	d by Funeral Director	11. Marital Status **XXNever Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Eve Armed Forces? 1 ☐ Yes 20XNo If Yes, Give Year or Dates:		Was Decedent of H if Yes, specify Cuba 1 ☐ Yes XX No	lispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: W	
Maryland 21215-0036	within 72 h ene. than "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of wo d)	rking 16	b. Kind of Business/I	ndustry
nd 2	be filed v ntal Hygie ed other t	Be	12 17. Father's Name (First, Middle, Last) Edward Michael Blei	or		Mechani	18. Mother's Na	ne (First, Middle, Ma Krammer		
<u>Z</u>	s 1 and 2 should be i Health and Mental item 27 is marked o other traumatic eve	ဥ	19a. Informant's Name/Relationship (Typ.		19b. Mailir	ng Address (Street			City or Town, State, Z	ip Code)
	d 2 th a		Herta Bellefleur			Greenfie		Stafford,	VA 22556	
nore	Pages 1. nent of He int: if item iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ত Cremation 3 ☐ Re	moval nom State	20b. Place of Dispo cemetery, crei		1		c. Location - City or 1	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Cervice License			2. Name and Addre	ss of Facility Ha		altimore, neral Home MD 21401	
ř	Physician		23a. Part1. Enter the disease, o complication of complex shock, or heart failure. List only on immediate Cause (Final disease or condition	eations that caused the e cause on each line.	e death. Do not ent				1,	Approximate Interval Between Onset and Death
j)	/Medical Examiner		resulting in death)		onsequence of):					Gmonth
8760,	cate be executed physicien and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	De rtcusi					20years
O. Box 6	The iaw requires thei the death certificate be executed ate has been signed by the attending physicien and bage 2 should be deteched for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at tim	Fetal death 3	Ectopic pregnancy	,		23d. Date of deline	very Day Year
rds, P.	quires thet n signed b uld be dett	d by PI	Part II. Other significant conditions con	tributing to death but r	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Records,		Completed						24a. Was an autopsy performe	prior to c death?	topsy findings available ompletion of cause of
Vita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?			100		ath (Check only one)		
Division of	ang Ph After th funeral	tion: To	1 Nes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	2 ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	4 🗆 Ivuising i	dome 5 Residence 28d. Describe how	be 6 Other (Specinium) occurred	ufy)
Divisi	To the Hospital or Attending within 24 hours after death To the Funeral Director: After completely filled in by the funeral properties of the funera	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, sti Specify)	reet, factory, office		28f. Location (Stree City or Town,	et and Number or Ru State)	ral Route Number,
	ne Hospit 24 hours ne Funere letely fille	Medicai C		ician: To the best of ner: On the basis of example and manner stated	amination and/or in					
)	To the To the comp	M	29b. Signature and title of certifier	3_	mo	29c. Licens			1. Date signed (Month	
7	-C4	31	30. Name and address of person who co	erbaum	my 1:	Print) 34 Ower	nsville	RD, WO	otober 27	My
20	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's	Signature	رگاری				

State

State 31. D Registrar Rakesh Arora, M.D. 14300 G

14300 Gallant Fox Lane

Bowie, Maryland 20717

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) NOV 0 1 2007



amend line 16a per fdPlease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 11/02/07 dlwState of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend Item 8 per fh, g878,04/11/08 this tificate of Death 2. Date of Death $30 \ 20^{\frac{\text{Year}}{0}}$ Month **Physician** October 2:14A M Helen Burley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton 8. Date of Birth 12/10/38 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □XF Maryland 220-38-1762 68 Yrs. Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or iminer must be r 4327 Canyonview Dr. 20772 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after of ealth and Mental Hygiene. 1 Never Married Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: þ Specify: Black 3 Widowed 4 Divorced "natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEKA HOMEMAKER 10th 0 N/A traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Jones Victoria Gray and l 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is 4327 Canyonview Dr. Upper Marlboro, Md.20772 permit. Pages 1 an Department of Healtt. Important: If item or any Inter-Calvert S. Burley(Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Resurrection Cem 11-2-07 Clinton, Md. Menuame Resources of SaciliSons Mortuary, P.A. 21. Signature of Funeral Service Licensee Taxry H. Reese Mooff 3 | 821 West St. Annapolis,
23a. P.rt. Enter the disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to log s a consequence /Medical a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. List of Jordan, if Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 VUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 No 1□ Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Man of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier D0065111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) michael Frasier mp 7503 Surratts RD Clivton, md 20735 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

DHMH 17 Rev 1/2001

Registrar

NOV 0 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** OCTOBER 27, 2007 CAROLYN ANN BLIGHT 3:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL GLEN BURNIE 124 MARTHA RD. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 □ 51 212-56-7387 Director MARYLAND 8-28-1956 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 Ves 2 No Director MD. ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21060 124 MARTHA RD. USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Ite Injury or other traumatic event, the Medical Examine 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE JOHNS HOPKINS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELISHA SMITH BETTY ANN McINTRUFF 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

WILLIAM BLIGHT (HUSBAND) 124 MARTHA RD. GLEN BURNIE, MARYLAND 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State METRO CREMATORY 4 □ Donation 5 □ Other (Specify)

20c. Location - City or Town, State 11-1-2007 BALTIMORE, MARYLAND

21. Signature of Funeral Service License HARRY complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part1. Enter the disease, shock, or heart failure. L

22. Name and Address of Facility WILLIAM REESE & SONS MORTUARY, P.A 821 WEST ST. ANNAPOLIS, MARYLAND 21401

Immediate Cause (Final disease or condition resulting in death)

ue to (or as a consequence of

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Year

Approximate Interval Between Onset and Death

5 Min

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months 1 ☐ Yes 2 ☐ No

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

3 ☐ Ectopic pregnancy

23d Date of delivery Month Day

4□Pregnant at time of death 9□Unknown

5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy

1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one)

2 ER/Outpatient 3 DOA

2 / HO

5 Residence

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 Xes 2□ No 27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be determined

NOV 0 5 2007

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year)

28c. Injury at Work? 28b. Time of Injury 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Other: 4 \sum Nursing Home

29d. Date signed (Month, Day, Year)

6 ☐Other (Specify)

Co 00 Ca 31. Date filed (Month, Day,

Registrar's Signature

DHMH 17 Rev 1/2001

Department of Health Important: If item 27

Physician

/Medical

attending physician and for use as the burial-trar

certificate

After

Director:

Funeral

To the

Examine

Physician/Medical

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Completed

Be

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Certification:

Medical

State

Registrar

Examiner

The law requires that the death certificate be executed

Box 68760

o

Division or Vital Records, P.

the Hospital or Attending Physician:

			For State Registrar	State of Ma	ryland		artment rtificate				-	Reg. No.		7	37119
	Physicia		1. Decedent's Name (First, Middle, La.	st)							Date of Dea Month	ath Day			3. Time of Death
	Physicia /Medic	al .	Kenneth R. Bar								Octobe:		200		01:49 AM
1	Examin	er	4a. Facility Name (If not institution, giv					_	Location o	f Death			County of D	eatn	
7		ds	Union Hospital o 5. Social Security Number 6. S			ast birthday)	If Under		If Under 2		8. Date of Birt	h	Cecil	Birthpl	ace (State or Foreign
	Funeral Director			XIM 2DE	57	Yrs.	Months	Days	Hours	Min.	(Month, Da) Nov. 5		49 Ma	Count [ary	Land
	P.		Usual Residence of Decedent			, Town or Lo	nation							10	d. Inside City Limits
	arylar show d at	_	10a. State 10b. County Maryland Cecil			rth Ea									1 ☐ Yes 2 📉 No
	he Ma 28a-f otifle	ecto	10e. Street and Number				10f. Zip	Code			T	10a. Citi	zen of What	Count	rv?
	with y		9 Ulmer Lane					901					ted Si		
	death ms 2:	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.	S. 13.			ispanic Ori	gin? (Spec	cify Yes or No Rican, etc.)		14. Race - A Black, V	merica	n Indian,
9	after or ite		1 ☐ Never Married	1 ☐ Yes 2XXV If Yes, Give	lo		1 ☐ Yes 2		Specify:	i, i deno i	110011, 010.)		Specify:		nite
21215-0036	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notifiled at	d by	3 Widowed 4 Divorced	Year or Dates:	-		dent's Usua		ation			16b Ki	nd of Busine		
2	illed within 72 h Il Hygiene. other than "nati rent, the Medica	Completed	15. Decedent's E (Specify only highest gra	ade completed)		(Give	kind of wor DO NOT us	k done c e retired	during mos ()	t of workin	g I				
12	withi jene. r than the M	omp	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Log	istic	s				Ma	nufact	turi	Lng
b	be filed within 72 hours after death with the Marylar ttal Hygiene. docher than "natural", or items 23a or 28a-f show other than "natural", or items 23a or or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle,	Maiden	Surname)		
/lar	should be nd Mental marked o	TOE	George Lewis Bar	rick							e Osca				
Maryland	and s m		19a. Informant's Name/Relationship (Donna A. Barrick				•	•			Route Numb st, Ma			<i>te, Zip</i> L 9 0]	
	1 and 2 Health tem 27 i		20a. Method of Disposition	/ WITE	20b. P	1							cation - City		
Baltimore,	permit. Pages 1 Department of H. Important: If iter any Injury or ott		1 X Burial 2 ☐ Cremation 3 ☐			lace of Dispo emetery, crei				Novem			-		Maryland
를	permit. Page Department of Important: If any Injury of any Injury of once.		4 □ Donation 5 □ Other (Special 21. Signature of Fugeral Service U.e.		5116	arps C		-			uch Fu				daryrand
ä	Depril Imperant		1 4khX/s												land 2190
3760,	Physician /Medical Examiner	lical Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Attero	SCONSEQUENCES	uence of: re he rence of:		1150	se	cardiac of	теѕріїасогу а	mest,			Approximate Interval Between Onset and Death Ln Knew
.O. Box 68	the death certificat y the attending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	Ideath 3	⊒Ectopic pr ⊒ Other (sp		/				23d. Date o Month		ry Day Year
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	Physician: The Is rethis certificate harral director, page 2	To	1 ☐ Yes 2 No			ER/Outpatie			4 🗆 140		ne 5 Resi			Specify	/)
N C	ding Ph J. After th funeral	ion:	27. Manner of Death 1. Natural 5 ☐ Pending investigatio	28a. Date of Inju (Month, Da)	Year)	Injury	M	8c. Injur Wor	yaı k? Yes 2□		du. Describe	now mju	ry occurred		
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	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical Ce	29a. Certifier (Check only one) Certifying P Certifying P	hysician: To the best of miner: On the basis of and manner sta	f examina	wledge, deat	th occurred	at the tir	me, date a opinion, de	nd place, a ath occurr	and due to the ed at the time	cause(s , date an	and mann d place, and	er as si	tated. the cause(s)
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b	⊢ ≯ ⊢ ō		- (DIN	S, Janul	ادر ي	wsiuur		0	5630	27		1	11/2/	200	
	15		30. Name and address of person who	completed cause of d	eath (Iten	n 23a) (Type,	, Print)								
-	10		Cydney T Te	11 .6.m h	1 6	est the	sh 57	rreci	S	mete ?	312	EIKHO	~ m	0	2192)
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07-08679 Par

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9 Botts		Please Type or Print in Black Indelible State of Maryland / Departmen	it of Health and Mental H	ygiene 2007 371.
20110	_	For State Certificate	e of Death	Reg. No.
Physician	/ 1	edistrar . Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year November 8, 2007 3. Time of Death 0747 hrs
l Examine	3 1	Pamela Botts a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Fort Washington	
		Fort Washington Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthd)	1400 0 040	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	- 1	6. Social Security Number 6. Sex 7. Age (In yrs, last birtho	Yrs. Months Days Hours Min	- Foreign ()
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Maryland 28a-f show any d at once.		MD Prince Georges Clint		1 X Yes 2 No
r 28a-f	<u>₽</u>	10e. Street and Number	10f. Zip Code	
items 23a o	<u>a</u>	11. Marital Status	20735 3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	Specify Yes or No- o Rican, etc.) 14. Race - American Indian, Black, White, etc.
old be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 33a or 28a-f sho event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes No 3 Widowed 4 Divorced If Yes, Give Yaar	1 Yes 2 X No specify:	specify: Black
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Hygiene. Hygiene. I other tl	틹	17. Father's Name (First, Middle, Last)	18.Mother's Nam	ne (First, Middle, Maiden Surname)
Mental H Marked marked c event, t	8	Fred Felder	Veron Mailing Address (Street and Number of	ica Burrows Rural Route Number, City or Town, State, Zip Code)
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permit. Pages 1 and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic e		20a. Method of Disposition 20b. Place of	Disposition (Name of cemetery, ry or other place)	Date 20c. Location - City or Town, State
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rmit. P epartme iportai jury or	1	21. Signature of Funeral Service Licentee	22. Name and Address of Facility Au	stin Royster Funeral Home
nysician	9	23a. Part I Enter the disease, or complications that caused the death. Do not	3821 14th Street.	N. W. Washington, DC 20011 c or respiratory arrest, shock, or heart Approximate Interval Between Onset and
aminer	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	nic right ventricular d	vsplsia
executed ian and ial - transi	ical E	MENDED AMENDED 27 per	ME,g874, 12/24/07 TT	
The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pres	gnancy 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death?
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Hospital or Attendi 24 hours after death. Funeral Director: tely filled in by the f	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, for determined (Specify)	arm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, Cit or Town, State)
To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical Ce	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in an an an an anner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	ed at the time, date and place, and due to the educate,
	, ×	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
To Yi	Ň	ill have to mo	O.C.M.E.	November 9, 2007
To wii	Me	30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner	O.C.M.E. 111 Penn Street, Baltimore, N	

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 7 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Year Hazel Leonnie Blanford 6:00pm 0ctober 31 2007 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heartland Healthcare of Adelphi Adelphi Prince George's 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Yrs. Director 218-68-3018 81 July 27, 1926 Nicaragua Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Director Maryland Prince George's New Carrollton 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6001 Westbrooke Drive Funeral 20784 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 A Yes 2 No Specify: þ Specify 3 ☑ Widowed 4 ☐ Divorced R1ack Nicaraguan Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Head of Housekeeping George Washington University 12 17. Father's Neme (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Herbert Robb 2 Rosa Anita Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Whittingham - Son 42 East Main Street, Inman, South Carolina 29349 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery 11/5/2007 Washington, D.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Hines-Rinaldí Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical crosclerolic Cardiovaseular dise Examiner Due to (or es a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the deeth certificate be executed ed by the attending physician end deteched for use as the bunel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ₽ No 3 ☐ Probably 4 ☐ Unknown Medical Certification: To Be Completed by this certificete hes been signe ral director, pege 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 100 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours efter deeth.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Deeth 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigetion 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number 00 D0060100 MD 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

HHM LWH C ALTMED, MD 831 32VD 2090 University vers pr 31. Date filed (Month, Day, Year) NOV 05 32 Registrer's Signature State 2007

DHMH 16 Rev 6/95

Registrar

DHMH 17 Rev 1/2001

Registrar

NOV 0 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fd aaco hlth dept 11/07/07 dlw State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Lynne Donald Calhoun 200 ctro /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Glen Burnie Baltimore Washington Medical Center Birthplace (State or Foreign Country) 8. Date of Birth (Month By) 18 **Funeral** Days Hours 1 □ M 2 1 F Months Min 89 213-03-2725 9/18/1918 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2X No Anne Arundel Annapolis MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number A HOW 21403 USA 170 Acton Rd. by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2554No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify. 3.☐Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Medical Records Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) NWE Be India Robinson Tilghman M. Price ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, MD 21403 Lawrence Earle Son 170 Acton Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/1/2007 Herndon, VA Chestnut Grove 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Tal, 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of discr, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical s a consequence of Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury ence of) Examiner The law requires that the death certificate be executed Dm that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? 1☐Yes 2☐No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 000 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy page 2 1∐ Yes ours after death.

eral Director: After this certification by the funeral director, To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Tes 2 No 1 npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Injury 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Frint) 31. Date filed (Month, Day, State NOV 0 1 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12.58 AM 10/30/2007 Tilghman Clayton Coale /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Country) Months Hours Min. 1171571920 1**%** M 2□ F 86 217-14-5323 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitied at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Queen Anne 1 ☐ Yes XXNo Director MD Stevensville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 109 Rock Lane 21666 IISA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No 1942-If Yes, Give Year or Dates: 1944 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 □ Yes 🔏 🛱 No Specify. White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transportation Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leonard William Coale Nettie Wolf 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille Coale Wife 109 Rock Lane Stevensville, MD 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem 11/5/2007 Crownsville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Servi 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequent of) disease or condition resulting in death) JCS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons of ence of): Examine the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the attending IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 ™ Onknown Completed peen: 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 Yes 2 No ဂ္ 1 🔲 Inpatient 2 ER/Outpatient this completely filled in by the funeral 28b. Time of 27 Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury Attending (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 0

within 24 hours after death. To the Funeral Director: After Hospital

Medical To the State

1 ctthe

29b. Signature and title of certifier

29a. Certifier

29d, Date signed (Month, Day, Year)

Cout suite 201 Annipolis MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Multa 132

32. Resstrar's Signature

31. Date filed (Month, Day, Year) NOV 0 2 2007

Registrar

1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 3, Charles Benner Charsha November 2007 3:30 A^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 840 Craigtown Road Port Deposit Cecil 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X**M 2□ F 71 215-34-0201 Director March 14, 1936 Georgia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County show or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Port Deposit Maryland Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21904 USA 840 Craigtown Road Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Itel 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Construction traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Milton Charsha Emily Lloyd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol D. Charsha/Wife 840 Craigtown Road, Port Deposit, MD 21904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State Department of Important: If It any Injury or o oonce. 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-07-2007 4 Donation 5 Other (Specify) Bethel Cemetery Chesapeake City, MD Signature of Funeral Service Licensee 22. Name and Address of Facility R. T. Foard Funeral Home, P.A. 318 George Street, Chesapeake City, MD 21915 whas used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ch line. 23a. Part Enter the disease, or complication of heart failure. List only of Immediate Cause (Final Physician ardiopulmonari disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner 10 years Sequentially list conditions, Due to (or as a consequence of) Examiner If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation ours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, Hospital

> State Registrar

within 24 hours a

Medical

29a. Certifier

31. Date file

(Check only

29b. Signature and title of certifier

wo.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Year!

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

T) 0063981

669 Revolution St. Havrede Grave, MD 21078

29d. Date signed (Month, Day, Year)

		·	1 - For State Registrar	State of	Marylar				ealth a	and Me		giene Reg. No	ZUUI	37126
			Decedent's Name (First, Middle, Last	1)						1	2. Date of Dea Month	ith		3. Time of Death
	Physici /Medic	an al	Robert Marcos Camp	bell, S	r.					l	Novembe	er 5		7:48 P ^M
	Examir		4a. Facility Name (If not institution, give	street and numb	oer)		4b. City	Town, or	Location of	of Death		- 1	. County of Death	
			Kline Hospice Hous					int A		0411			Frederic	
	Funeral Director		5. Social Security Number 6. Se 217-44-8256	X 2 F 7.	. Age (In yrs. 62	last birthday) Yrs.	Months	r 1 Year Days	If Under Hours	Min.	B. Date of Birth (Month, Day Oct. 13	(, Year)	Coi	nplace (State or Foreign untry) ington, D.C.
	pu k		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	oation							10d. Inside City Limits
	Manylan II show	tor	Maryland Frederic	k		Freder								1 ☐ Yes 2XNo
	r 28s	Director	10e. Street and Number		1	IICUCI		p Code				10g. Ci	tizen of What Co	untry?
	th wit		6707 Kernel Court				2	21703				Uni	ted Stat	tes
36	72 hours after death with the Maryland naturel; or iteme 23e or 28e-1 show dreal Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Force 1 Tyes 2 If Yes, Give	es? ☑No	+			spanic Ori n, Mexican Specify:	gin? (Spec i, Puerto R	ify Yes or No- ican, etc.)		14. Race - Amer Black, White Specify: Wh	
Ş	n 72 hours a "naturel", c	edh	15. Decedent's Ed	Year or Date	95:	16a. Dece	dent's Usu	al Occupa	ation			16b K	(ind of Business/I	Industry
15	⊆	Completed	(Specify only highest grad	de completed)	l== 5 · \	(Give	kind of wi	rk done d	lurina mosi	t of working	9	100.1	and of Dasinessy	industry
212	d within giene. rrthen	E O	Elementary/Secondary (0-12)	College (1-4	or 5+)	Auto	Body	Mec	hanio	2		Aut	omobile	Repair
b	be filed Ital Hygi od other event, t	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,			
<u>a</u>	should be ind Mental marked o	Tof	Robert Lee Campbel	.1					Remi	lgia l	Borras			
a	and and summer		19a. Informant's Name/Relationship (T	ype, Print)		1							or Town, State, Z	lip Code)
3,2	1 and 2 Heelth tem 27 i		Jane Campbell / Wi	.fe	100	_	Shifte World Continued	with Michigan	. Fre		ck, MD			
Baltimore, Maryland 21215-0036	m O		20a. Method of Disposition 1 Burial 2 Cremation 3 Disposition	Removal from St	ato (Place of Dispo cemetery, crei	natory or	other place		Nov.	7,	20c. L	ocation - City or	Town, State
ţ	t. Pa ntmen ntant: njury		4 □ Donation 5 □ Other (Specify,		Kes	sthaver				2007				Maryland
Bal	permit. Page Department important: If any injury or		21. Signature of Funeral Service Licens			9	501 (Catoc	tin M	Itn. I	lwy. Fr	ede	kkot Coorick, MI	dy P.A. D 21701
	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease or compshock, or heart failure. List only of list only of disease or condition resulting in death) Sequentially list conditions, and the course. Enter Underlying Cause. Enter Underlying Cause (Disease or injury)	Due to (or b Alcoho	osis rasaconsec	quence of):	er me mo	de or dylini	g, such as	cardiac or	respiratory an	rest,		Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed sie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	r as a consec	quence of):								
O. Box	at the death certific by the attending p tached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ∐ Feta ntattime of d	al déath 3[]Ectopic p] Other (s)						23d. Date of deli Month	very Day Year
rds, P.	w requires that been signed t should be det	þ	Part II. Other significant conditions co	ntributing to dea	th but not res	sulting in the u	nderlying (cause give	in in Part I.		1	bacco es 2		the cause of death?
of Vital Records,		Completed									24a. Was autop perfor 1 Yes	sy med?	prior to death?	topsy findings available completion of cause of
/ita	cian: ertific ector.	Be (25. Was case referred to medical examiner?						26. Place	of Death	Check only or	ne)		
	ding Physician: h. After this certifications funeral director.	tlon; To	1 Yes 2 SNo 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	Hospital: 1 ☐ Ing 28a. Date of (Month,		ER/Outpatier 28b. Time o Injury		28c. Injury Work	4 🗆 INU	28	e 5 Resid			hy)Hospice
Division	To the Hospitel or Attending within 24 hours eftar death. To the Funeral Director: Afte completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined		f Injury - At h	ome, farm, str	eet, factor				Bf. Location (S City or Tow			ral Route Number,
	e Hospitel 124 hours Euneral letely filled	edical (29a. Certifier 1 Certifying Phy (Check only one)	sician: To the bas	is of examina	owledge, deat ation and/or in	h occurred vestigation	at the time n, in my op	e, date an pinion, dea	d place, ar th occurred	nd due to the o	ause(s date an) and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29	c. License	number			29d. Da	ate signed (Monti	n, Day, Year)
			• \ \ \ \				1	2004	0107	1		11	17/17	•
-			30. Name and address of person who c	ompleted cause	of death (Iter	m 23a) (Type,	Print)			•		• •		
5			Diana Juliano, M.D						MD 2	21703				
	Sta Registr		31. Date filed (Month Day Year) 7	007 32. 8	gistrar's Signi	Jr /g	bash	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		'	1- State of Maryland / Department of Certificate of Registrar		Reg.	No. 2007	37127
	Physicia	an	1. Decedent's Name (First, Middle, Last) William Patrick Delaney		2. Date of Death Month 10/28	Pay Year	3. Time of Death 6:31anM
	/Medic			, or Location of Death	10/20	4c. County of Dea	
				apolis		Anne Aru	
	Funeral Director		5. Social Security Number 122–22–0589 6. Sex 7. Age (In yrs. last birthday) 1		8. Date of Birth (Month, Day, Ye) 12/25/19	9. Bir 31 C	thplace (State or Foreign ountry) VY
	Maryland -f show fled at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Anne Arundel Annapolis				10d. Inside City Limits 1 □ Yes 🍇 No
	with the	I Direc	10e. Street and Number 10f. Zip Code 307 Cedar Lane	21403	10g.	. Citizen of What Co	ountry?
320	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director		of Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	iin 72 hou n "natura Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	cupation ne during most of work ired)	ing 16	b. Kind of Business	/Industry
717	ed with giene er tha er, the	Com	Financial An			US Govern	nment
/land	ld be filk lental Hy ked oth Ic event	To Be	17. Father's Name (First, Middle, Last) Edward J. Delaney		e (First, Middle, Mai Bradshaw	,	
Mary	2 shou and M is mar aumat		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Stre	eet and Number or Rur	al Route Number, C	ity or Town, State, .	Zip Code)
e Ge	1 and 1 Health em 27 ther tr		Anna Delaney Wife 307 Cedar La 20a. Method of Disposition 20b. Place of Disposition (Name of		olis, MD	21403 c. Location - City or	Town State
saitimore,	Pages nent of h ant: If ite ury or of		txxBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) Cemetery, crematory or other to the first term of the first	tery 11/1	/2007 Cr	ownsville	e, MD
pair	permit. Departr Imports any Inj. once.			dress of Facility Ha y Ave. An			ne, P.A.
	Physician /Medical Examiner		resulting in death) Due to (or as a consequence of):	dying, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
on,	rificate be executed g physician and as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
×	n certificate anding physical use as the	n/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of de	livery
j.	that the death cer ed by the attendin detached for use	Physician/N	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnated time of death 5 Other (specify, 9) Unknown			Month	Day Year
us, г	w requires that s been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Did tobac		o the cause of death? robably 4 Unknown
ec L	sician: The law rec certificate has bee irector, page 2 shou	Completed			24a. Was an autopsy performe	prior to	
	cian: ertifica ector, p	Be C	25. Was case referred to medical examiner?		h (Check only one)		
0	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	은	27. Mann of Death 1 atural 5 Pending (Month, Day Year) Injury 28c. If	Other: 4 ☐ Nursing Honiury at Vork? ☐ Yes 2 ☐ No	ome 5 ☐ Residence 28d. Describe how		ecify)
	al or Atte s after dea il Directo ed in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, offine building, etc. (Specify)	ce	28f. Location (Stree City or Town, S	et and Number or R State)	tural Route Number,
	ne Hospital of 24 hours af the Funeral Dietely filled i	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the desired form of th	e time, date and place, ny opinion, death occur	and due to the causered at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier 29c. Lice	ense number	29d	. Date signed (Mon	th, Day, Year)
)			20 Name and address of agreem who while a day of the 1 1 1 1 2 2 2 2 2 2	1) 5 33	00	10/29	101
10	HIGH		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Figure 32. Signature	d Ste 3	00 Ann	apolis	mn 2/401
	Sta Registr		NOV 0 1 2007				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a-f pere 1997 8873 15628/07dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Anne Frances Deckert Novembe /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington County 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1936 1 □ M 2 X F Months Days Hours New York 187-28-0805 71 Sept Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Smithsburg Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 22326 Republican Ave. 21783 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Teacher Board of Education 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph V. Donnelly, Sr. Anne F. Coby Donnelly ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Deckert - husband 22326 Republican Ave. Smithsburg Maryland 21783 F Health tem 27 Department of He. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Beaver Creek Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-10-2007 Hagerstown Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MUMARIC 5 days Well on has disease or condition resulting in death) /Medical Due to (or as a consequence of): RIPPURIN Examiner PROVED BY MEDICAL EXAMINE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the burial-trans Due to (or as a consequence of) 68760 CERTIF Physician/Medical use as Box IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4□Pregnant at time of death 9□Unknown 5 Other (specify) P.0. detached 1 ☐ Yes 2 🖾 No 9 ☐ Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by an 1 ☐ Yes 2√2No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy perform After this certificate 1∐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ▼ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) npatient ဥ 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: VI_nvatural 5 Pending investigation 2 X Accident 3 ☐ Suicide death. 11/02/2007 1 ☐ Yes 2 No Subject fell down stairs after death Unknown filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 22326 Republican determined 4 Homicide 0 Home within 24 hours a To the Funeral I Ave., Smithsburg, MD 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

00H-6

31. Date filed (Month

Hagerstown, MD 21740

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print),

MD

354

32. Registrar's Signature

Woney

			1 - State O	Maryland / Depa	artment of F tificate of	lealth and N Death	Лental Hyg в	iene eg. No.20	07 37130
7	Physici		Decedent's Name (First, Middle, Last) MARGARET URSELA	DEATON			2. Date of Deat Month 11		3. Time of Death 2007 1222 pM
	/Medic Examin		4a. Facility Name (If not institution, give street and nur. MEMORIAL HOSPITAL	-	4b. City, Town, o	r Location of Death		4c. Count	y of Death EGANY
****	Funeral		1□M oFFE	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
-	Director		Usual Residence of Decedent	89			02/16/1	918	Maryland
	Marylar -f show fied at	to	10a. State 10b. County MD Allegany	10c. City, Town or Lo	nberland				10d. Inside City Limits 1 🏋 Yes 2 🗆 No
	or 28a	Director	10e. Street and Number		10f. Zip Code	21502	1		What Country?
	ms 23a	Funeral	221 Pear Street 11. Marital Status 12. Was Dece	dent Ever in U.S. 13. \		21502 lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Ra	ce - American Indian,
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Fur	Armed Fo 1 □ Never Married 2 □ Married 1 □ Yes 3 ☒ Widowed 4 □ Divorced Year or D	2 🕅 No	lf Yes, specify Cuba 1 □ Yes 2[X] No	an, Mexican, Puerti Specify:	Rican, etc.)	Speci	
9500-61212	72 hour natural lic i Ex	eted b	15. Decedent's Education (Specify only highest grade completed)	16a, Deced	dent's Usual Occup	oation	king	16b. Kind of E	White Business/Industry
121	within ene. than "	Completed	Elementary/Secondary (0-12) College (1	-40r 5+)	gal Secr	during most of word	(Ing	Larr	Firm
פר	e filed al Hygi l other vent, t	Be C	17. Father's Name (First, Middle, Last)	l re	gar becr	18. Mother's Nam	ne (First, Middle, I	Maiden Surna	
Maryland	should be ind Mental simarked or umatic eve	면 명	Thomas Francis Hannon	405 M-32		Versa		Dailey	
	ages 1 and 2 should but of Health and Ment it if item 27 is marked or orther traumatic e		19a. Informant's Name/Relationship (Type. Print) Thomas A. Dombrosky / S			reet, Cun			a, State, Zip Code) 21502
Baltimore,	Pages 1 a nent of He ant: If item ury or othe		20a. Method of Disposition 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from	20b. Place of Dispo cemetery, cren		1			- City or Town, State
	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) 21. Si nat re of Funeral Service Licensee		Cemetery Name and Addre		7/2007 ams Fami	Baltiı lv Fun	more, MD eral Home, P.A.
ñ	Dep imp any		Meller & ada			ır Street			
	Physician /Medical Examiner		resulting in death) Due to	ach line. IC OBSTRUCTIV or as a consequence of):	-			est,	Approximate Interval Between Onset and Death
,097	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequence of):					
Š	ertificate ing phy e as the		IF FEMALE:		_				
O. Box	the death certific y the attending p	Physician/Med	23b. Was decedent pregnant 23c. if yes, out	ant at time of death 5	Ectopic pregnancy Other (specify)	у			ate of delivery Ionth Day Year
Records, P	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions contributing to de	eath but not resulting in the u	nderlying cause giv	ren in Part I.			ntribute to the cause of death? 3 ☐ Probably 4 ⊠Unknown
		Completed					24a. Was a autops perform	sy	. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
VITa	Physician: r this certifica aral director, p	o Be	25. Was case referred to medical examiner? 1 \(\triangle \triangle Yes \) 2 \(\triangle \triangle No \) Hospital:	npatient 2 MER/Outpatien	ot 3 DOA Oth	26. Place of Dea ler: 4 ☐ Nursing H	th Check onl on		ther (Spacify)
n o	ng infle		27. Manner of Death 28a. Date		f 28c. Injui	ry at	28d. Describe h	ow injury occu	irred
DIVISION OF	Atten r dear ector by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be	of injury - At home, farm, str ng, etc. <i>(Specify)</i>		Yes 2□No	28f. Location (Si City or Town	treet and Num n, State)	nber or Rural Route Number,
	he Hospitai or in 24 hours afe he Funerai Dir pletely filled in I	Medical C	29a. Certifier (Check only one) Check only one) Check only 2 Medical Examiner: On the band man	best of my knowledge, deatl asis of examination and/or in ner stated.	h occurred at the ti vestigation, in my	me, date and place opinion, death occu	, and due to the corred at the time, co	ause(s) and n late and place	nanner as stated.
		Σ	29b. Signature and title of certifier		29c. Licens		2		ed (Month, Day, Year)
1	4		30. Name and address of person whiteompited caus	e of death (Item 23a) (Type,		-		Nev 4	2007
	nes		SUNIL GUPTA, M.D. 625 31. Date filed (Month, Day, Year)	KENT AVE., CU egistrar's Signature	MBERLAND	,MD 21502			
	Sta Registr		NOV 0 6 2007	egistrar's Signature	Whis .				

			For State Registrar	State of Ma	arylan	d / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of H te of L	ealth a Death	and Me		giene Reg. No		7	371	31
	Physici /Medic		1. Decedent's Name (First, Middle, Las MARGARET B •	EMORY							2. Date of Dea NOVEMI		^y 15 2	ar	7:40a	
	Examir		4a. Facility Name (If not institution, give Chester River						Location o			40	County of E Kent			
	Funeral Director		213-20-1231	x 7. Ag □ M 2(2 5 F	e (In yrs. I 91	ast birthday) Yrs.	If Under	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da June 1	h y g ^y ear	9.16		(State or Fo. yland	
	tiled within 72 hours after death with the Maryland Hygiene. Ither than "naturel", or iteme 23s or 28s-1 show int, the Medical Examiner must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County MD Kent			y, Town or Lo		'n							Inside City Li	
	with th	Dire	10e. Street and Number 400 Morgnec Ro	- Amb	1			ip Code				•	tizen of Wha	t Country?		
	ne 23	Funeral	11. Marital Status	12. Was Decedent		S. 13.		1620	ispanic Orio	gin? (Spec	ifv Yes or No		S.A.	American I	ndian,	
036	ours after d	Ď	1 Never Married 2 Married 3 XVidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🐼 If Yes, Give Year or Dates:			lf Yes, sp 1 ☐ Yes		n, Mexican Specify:	i, Puerto R	ofy Yes or No lican, etc.)			White, etc. Whit		
1215-0	vithin 72 ho ne. han "natur e Mevical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0·12)		5+)	life.	kind of w DO NOT	ual Occupa rork done d use retired	during most)	t of working	g		ind of Busin		•	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "naturel", or iteme 23s or 28s-1 show other traumatic event, the Medical Examinar mant be notified at	Be	12 17. Father's Name (First, Middle, Last) Stephen Bosti						18. Mothe	or's Name :	(First, Middle,			9 1101		
ary	shoul ind Ma s marl umati	၉	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailie	ng Addre	ss (Street a			Route Number	er, City	or Town, Sta	ite, Zip Coo	de)	
	and 2 salth s n 27 is		Patricia Parde	e (daug) 113		_	h Rd	. W	orton	-				
Baltimore,	or oth		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	0	lace of Dispo emetery, crea	matory or	other plac	(a)		ate		ocation - Cit	-		
Ë	t. Pag ntment rtent:		4 ☐ Donation 5 ☐ Other (Specify)	St						0/07					
Bal	permit. Pages 'Depertment of the Important: If ite eny injury or ot one		21. Signature of Funeral Service Com		M005	10 1	8 W	est	Cros	s St	me of . Gal	<u>ena</u>	epher , MD	. 216	535	ech
,	Physician /Medical		23a. Påt1. Enter the disease, or composition shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. CELEB Due to (or as	ne. RDV)	1 Scul						rrest,		On	proximate erval Between set and Deat day S	th
8760,0	icate be executed by physician and burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or as d.												
P.O. Box 68	The law requires that the death certific ate has been signed by the attending pl page 2 should be detached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	I death 3	⊒Ectopic ∃ Other (pregnancy specify)					23d. Date o Month		y Year	г
rds, P	quires that n signed b uld be deta	d by Pl	Part II. Other significant conditions of DEMENTIA	ontributing to death b	ut not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did t		1		ause of death	
Vital Records,	The law require te has been sit age 2 should b	Completed by	ATRIAL FIBR	ILLATIO	N								prio	r to comple th?	findings availation of cause	ilable e of
ital	len: rtifica stor. p	BeC	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only o			163 242		
<u>></u>	hysic his ce I direc	70	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 Inpatio	ent 2	ER/Outpatie	nt 3 🗆 🛭	Oth	er: 4 Nu	rsing Hom	e 5 ☐ Resi	dence	6 Other	(Specify)		
Division of	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		iry y Year)	28b. Time o Injury	f M	28c. Injun Worl 1 🗀	yat k? Yes 2 □ !		8d. Describe	how inju	iry occurred			
DIX:	ital or Atl urs after d rel Direct		4 Homicide determined	building, et	c. (Specif	y)					8f. Location (. City or To	wn, Stat	e)			
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	one)	ysician: To the best niner: On the basis o and manner st	t examina	wledge, deat tion and/or in	vestigatio	on, in my o	pinion, deal	d place, au th occurre	nd due to the d at the time,	date an	id place, and	due to the	cause(s)	
)	To with	2	29b. Signature and little of certifier	MM			2	9c. Licens	0 0 4	15	87	29d. Da	ate signed (A	Month, Day	Vear)	
	3		30. Name and address of person who Helen A. Nobl	e, M.D.	12:	2 Spe		d. C	hest	erto	wn, M	D.	2162	0		
	Sta		31. Date filed (Month, Day, Year)	32. Registr	rar's Signa	iture Aos	alle s									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** Year 2007 1:35 PM Coletta 11 /Medical Emerick 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 14701 Coletta Ln. Mount Savage 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1□M 2XF Director 213-24-6592 78 3-21-1929 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Allegany Mount Savage 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Coletta 14701 Ln. 21545 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Ď Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker <u>Own Home</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be <u>Joseph Durkin</u> 2 <u>Julia Sullivan</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 224 Rose Haven Rd., Hyndman, PA 15545 of Disposition (Name of Date 20c. Location - City or Town, State Julia Huston/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lutheran Cemi 11-5-2007 Wellersburg, PA 22. Name and Address of Facility Harvey H. Zeigler Funeral 21. Signature of Funeral Service Licenses 23a. Part1. Inter the diseas of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure is strongly one cause on each line. Approximate Interval Between Onset and Death Immediate Jause (Final disease or condition resulting in death) **Physician** Zung Corcu mer /Medical Due to (or as oconsequence of): Examiner Sequentially list conditions, if any Lading to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending I 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1. Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 → No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760 Ö Records, P. or Vital

To the Hospital or Attending To the Funeral Director: completely filled in by the after within 24 hours

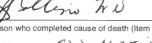
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State Registrar

Medical

29a, Certifier (Check only one)

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and manner stated.

29c. License number 0017565

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

922 NZTI 32. Registrar's Signature

31. Date filed (Month, Day, Year) NOV 05 2007 Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

For State	State 0	ı ıvıaryıa		-	ment of F ficate of			icilial M		01	20	-7	0 7	10
Registrar	noth			Certii	icale of	Dealli		2. Date of D	Reg.	No.	JU		3. Time	of Death
Decedent's Name (First, Middle, L								Month		Day	Ye	ar	}	M
MINNA	FELD			416	o. City, Town, o	r Logation		NOVEMBE	R 2,	2007 4c. Coun	ty of F	Death	5:45	A
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SUBURBAN HOSPITAL Social Security Number 6.	Sex	7. Age (In yr	s last hirt	hday) · If	BETHESI FUnder 1 Year		24 Hrs.	8. Date of E	Birth	MONTO			place (State	or Forein
577-60-4889	1 M 2 ∏ F	91			Ionths Days	Hours	Min.	(Month, I	Day, Y	ear)		Coui	ntry) SYLVANI	
Oa. State 10b. County		10c. 0	City, Town	or Location	on							1	10d. Inside	-
MARYLAND MONTGOME	RY	NOF	TH BE	THESDA	A								1 □Y∈	s 2 No
0e. Street and Number				1	10f. Zip Code				10g	. Citizen o	f Wha	t Cou	ntry?	
5550 TUCKERMAN LANE						20852			1	U.S.A	Δ			
Marital Status		edent Ever in	U.S.	13. Was	s Decedent of 1 es, specify Cub		igin? (Sp	ecify Yes or I	No-	14. R	ace - /		can Indian,	
1 Mover Married 2 Married 3 Widowed 4 Divorced	Armed Fo 1 ☐ Yes If Yes, Gi Year or D	2 ∑ No ve			es, specify Cub Yes 2⊠ No			Rican, etc.)			lack, V			
15. Decedent's	Education		16a.		t's Usual Occu				16	b. Kind of	Busin	ess/In	ndustry	
(Specify only highest g	rade completed) College (1-4or 5+)	-	life. DO	d of work done NOT use retire	auring mos d)	st ot work	ıng	NΔ	TIONAT	, TN	ISTT	TUTES	OF
Lienieniary/Secondary (0°12)	4	1 -101 01)	MED	ICAL 1	TECHNOLOG	GIST			142		EALT		LULED ,	
7. Father's Name (First, Middle, La.	st)					18. Moth	er's Nam	e (First, Midd	lle, Ma	iden Surn	ame)			
SAMUEL	FEL	D				SARAH	I		SCF	IERZER				
19a. Informant's Name/Relationship			19b.	Mailing A	Address (Stree			al Route Nun			ın, Sta	ate, Zij	p Code)	
ELEANOR PRISSMAN/SI	STER		311	2 ADD	ERLEY CO	דא ידיקוו	LVFR	SPRING	MΔR	VT.AND	209	906		
0a. Method of Disposition	DIDIC	20b	. Place of	Disposition	on (Name of	i		Date					own, State	
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osys am Division or Vital Records, P.O. Box 68760, Feld, Minna 11/2007

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State

Registrar

29c. License number 20066003 29d. Date signed (Month, Day, Year)

NOVEMBER 2, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HELINA KASSAHUN, M.D., 8600 OLD GEORGETOWN ROAD, BETHESDA, MARYLAND 20851

31. Date filed (Month, Day, Year) NOV 0 5

29b. Signature and title of certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 37134

			- For State Registrar			Certific	cate of	Death			Re	g. No.	. • •	7 0710
	Physicia		Decedent's Name (First, Midd)	e,Last)		-	-			i n	Date of Death Month	Day Yea		3. Time of Death
Medi	cal Exami		Kaitlynn Ma	rie Ford						N	ovember	8, 2007		1414 hrs
			4a. Facility Name (if not institution		imber)		4t	o. City, Town, or		of Death		4c. County of Washing		
			251 E. Antietam Stree					Hagerstown		1.				
	Funeral		5. Social Security Number unk	6. Sex	7. Age (Ir	n yrs. last b	irthday)	If Under 1 Year Months Days				h(MM/DD/YYYY	Foreign	nplace (State or ntry) Maryland
	Director			1XM 2F			Yrs.	1 12	, nouis	IVIII.	Sept	26 2007	Cour	ntry)lar y Lanu
			Usual Residence of Decedent											10d. Inside City Limits
	v any		10a. State 10b. County		100	c. City, Tow	n or Locatio							1 X Yes 2 No
	and Show	5		hington			Hage	rstown						
50	Maryl 28a-1 d at c	Director	10e. Street and Number					10f. Zip Code			10	g. Citizen of W		iry?
1038	vith the Maryland s 23a or 28a-f show a e notified at once.		1056 G Nola	nd Drive				217					S.A.	
-	eath with items 2 ust be n	Funeral	11. Marital Status	12. Was De Armed F		er in U.S.	13. Was	Decedent of His	panic Orig	gin? (Specit , Puerto Ric	fy Yes or No- an, etc.)		e - Americ e, etc.	can Indian, Black,
	deat or ite	ᆵ	1 X Never Married 2 N	1 Yes	2 X	No							Wł	nite
	after al", iner	ρ		vorced If Yes, Give Ye or Dates:				Yes 2 X No				Specify:		
	hours natur	eq	15. Decedent's Education (Spe			ted) 16a		's Usual Occupat st of working life				16b. Kind of Bi	JSINESS/III	idustry
9	172 n 72 ian "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			N/A				١,	N/A	
	5-0036 led within 7 Hygiene. other than	mo	O Transport Tra	L cot					18 Mother	r's Name (Fi	rst Middle N	Maiden Surname		
!	filed I Hyg	ادہ	Jeffery Way							,			,	
	2121 ould be fill Mental Is marked ic event,	To B	19a. Informant's Name/Relation				19b. Mailing	Address (Stree	et and Nun	mber or Rura	ette f	Behanna ber, City or Tox	vn, State,	, Zip Code)
	Baltimore, MID 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath is and Mental Hygiers, Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	-	Patricia A. Pe		dmoth			G Nolan						
	Baltimore, MD oremit. Pages 1 and 2 sho Department of Health and Important: If item 27 is niury or other traumati		20a. Method of Disposition				e of Disposi	tion (Name of ce	metery,	D	ate	20c. Location	- City or	Town, State
	Ore ges 1 t of F t of F i If i		1 X Burial 2 Cremation	n 3 Removal	rom State	Rest	hatory or oth Haver	er place) 1 Cemete:	rv	11-1	2-2007	Hagers	stowr	n Maryland
	timen rtmen rtaut		4 Donation 5 Other S 21 Signature of Funeral Service					ame and Address		1				
	Baltimo permit. Page Department o Importaut: injury or oth			A to Z							igias <i>H</i> N. Has	. Fler	/ Fun 1 Mar	neral Home ryland 21742
			23a. Part I. Enter the disease, d	r complications that,	caused the	e death. Do								Approximate Interval
-	Physician (Medical		failure. List only one cause	e on each fine.										Between Onset and Death
1	faminer	ļ	Immediate Cause (Final diseas or condition resulting in death)	e a. <u>Sudden</u> Due to (or as			n synar	ome						
			O	b.		,,								
		Эeг	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequ	ience of):								
		Examine	cause. Enter Underlying Cause (Disease or injury that initiated	C.	a conseni	ience of):								
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	687(certifica nding ph se as the	_ =	23b. Was decedent pregnant in past 12 months?	<u></u>	birth	or program		tal death 3	Ectopi	ic pregnanc	у	Month	Γ	Day Year
	th cer ttendi	100		nknaun		ne of death	5 Ot	her (Specify)						
	Box ne death c the atten ned for us	Physiciar		a Olik	nown			7-11	olona la D	N-m 1	230 Did t	obacco use con	tribute to	the cause of death?
	ecords, P.O. Box 68 he law requires that the death certif are has been signed by the attending age 2 should be detached for use as	by P	Part II. Other significant cond	itions contributing	to death b	ut not resu	iting in the L	inderlying cause	given in P	anı.				bably 4 Unknown
	S, F uires n sign d be										24a. Was			utopsy findings available
	w req	olet									auto	psy		completion of cause of
	lec The la ate ha	Completed									1 Yes	ormed? 2 No	1 Y	es 2 No
	of Vital Records, ng Physician: The law require After this certificate has been simeral director, page 2 should be	S S	25. Was case referred to medic	cal		_		26.Plac	e of Death	h (Check on	ly one)			
	ivision of Vital or Attending Physician: after death. Director: After this certif in by the funeral director,	0	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2 🗸 EF	VOutpatient	3 DOA	Other ₄	Nursing	Home 5	Residence 6	Othe	r:
	of ng Ph \fter i neral	=	27. Manner of Death	28a. Dai	e of Injury th, Day,Yea	r) 28	b. Time of I		ury at Wor	_	8d. Describe	how injury occu	ırred	
	On tendi eath or: /	읉		nding estigation				1	Yes 2	No				
- HE	Division tal or Attendii rs after death all Director: / led in by the fi	≝		uld not be	ace of Injur	ry - At home	e, farm, stre	et, factory, office	building, e	etc. 2	8f. Location or Town,		nber or Ru	ural Route Number, City
-1	Dital ours at urs at Illed	Certification:		termined (Specif	y)						01 101111			
	the Hospital hin 24 hours a the Funeral	a C	29a. Certifier 1 Certifying	Physician: To the b	est of my l	knowledge,	death occu	rred at the time, o	date and p	olace, and d	ue to the cau	se(s) and manr	er as stat	ted.
	Division of V To the Hospital or Attending Ph within 24 hours after death To the Funeral Director: After t completely filled in by the funeral	Medical	one) 2 Medical Ex	caminer: On the basi	s of examination of stated.	nation and/	or investiga	tion, in my opinio	on, death o	occurred at 1	he time, date			
_	F > F 5	ž	29b. Signature and title of certi	fier	0			29c. Licer		er				onth, Day, Year)
			Milana B.	assell it	10			0.0	.M.E.			Novembe	∍r 9, 20	07
			30. Name and address of person	on who completed ca	use of dea	ath (Item 23					_			
JH-	0		Melissa Brassell, MD		ledical E	Examine	111 F	Penn Street,	Baltimo	re, MD 2	1201			
		state		5 2007	1	Signature								
	OCME													
DH	MH 17 Rev 1/	2001		-			ORIGINA	\L						

			For State Registrar	State	of Marylar	•	artment of H				giene	000	27125	
			Decedent's Name (First, Middle)	Last)						2. Date of Dea	ath		3. Time of Death	-
	Physicia /Medic		Mildred Elia	zabeth Fi	cee]	Month Novembe	Day er 2		7:55AM M	
	Examin		4a. Facility Name (If not institution,	give street and n	u <i>mber</i>)		4b. City, Town, or	r Location	of Death		4c.	County of Death		
			26522 Harbor		1		Princess					Somerset		_
H	Funeral Director		579-88-7849	6. Sex 1 □ M 2 F	7. Age (In yrs. 96	Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	B. Date of Birt (Month, Date 08/06/			nplace (State or Foreign untry) aryland	
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits	_
	Mary -f sho	ğ	MD Somers	no.t	р	rinces	a Anno						1 ☐ Yes 2 No	
	r 28e	Director	10e. Street and Number	3CL	1 1	Truces	10f. Zip Code				10g. Citi	zen of What Cou	untry?	_
	hours after death with the Maryland tural', or Items 23a or 28e-f show at Example of must be invitibed at		26522 Harbor Ro	oad			21853	3				USA		
	ems	Funeral	11. Marital Status	12. Was De Armed F	cedent Ever in U	l.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Or	rigin? (Spec	ify Yes or No-	•	14. Race - Amer Black, White		
36	or it	by Fu	1 Never Married 2 Marrie	ed 1 ☐ Yes If Yes, G Year or	20 No		1□Yes 2 No	Specify:		,		Specify:		
5-0036	hour tural		3 ☐ Widowed 4 ☐ Divorced 15. Decedent*		Dates:	16a Dece	dent's Usual Occupa	ation			165 K	Wt nd of Business/l	nite	_
Ç	d within 72 hours after death with the Marylan Jibne. I than "natural", or Items 23s or 28e-1 show Ite Wadical Enarthet must be multiped at	Completed	(Specify only highes	t grade completed	·	(Give	kind of work done of DO NOT use retired	during mos	st of working	g	100.10	ild of Edsiriessii	ladstry	
717	filed within Hygiene. other than "	E O	Elementary/Secondary (0-12)	College	(1-4or 5+)	Н	omemaker				(Own Home	3	
힏	m - 0 2	Be C	17. Father's Name (First, Middle, L	.ast)				18. Moth	er's Name	(First, Middle,	Maiden	Sumame)		
Maryland		To I	Bernard Sweeney	7				Dais	y Seal	born		77 1000 - 1000		
<u>a</u>	2 short and in ma		19a. Informant's Name/Relationsh Vincent S. Free		1		ng Address (Street a				-			
	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		20a. Method of Disposition	e/ nusband			Harbor R	wau,	PIIII	-		cation - City or 1		
altimore,	permit. Pages 1 Department of H Important: If ite any injury or ott		1 Burial 2 ☐ Cremation		n State	cemetery, crei	natory or other plac	· (- 1				
	artme ortan injury		* 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service I		AS		.M. Cemet 2. Name and Address 2. nman Fund			2007	Mt.	vernon,	, Maryland	-
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-	Physician		pa, Part1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final	complications that	cal sed the dear	th. Do not ent	er the mode of dyin	g, such as	s cardiac or	respiratory ar	rest,	Anne, n	Approximate Interval Between Onset and Death	_
	/Medical		*Isease or condition resulting in death)	a. Due to	o (or as a consec	quence of):	Art	10	ilu	4			590	
	Examiner		Sequentially list conditions,	b	0000	w	Roth	crea	1	EPQ.	E e		3000	
	p tis	lner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a conse	uence of			-//				,	
_	and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a consec	uence of):								_
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9	ficate p phys	73		d.										
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	0 0	sicla	in the past 12 months?		birth 2 ☐ Feta gnant at time of c		Ectopic pregnancy Other (specify)	′				Month	Day Year	
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ř		Com						-		perfo	rmed?	death?	2□ No	
ıta	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						e of Death	(Check only o	ne)			
0	Physicien: r this certifica ral director, p	2	1 ☐ Yes 2 € No 27. Manner of Death	-		ER/Outpatier		4 🗆 INI				Other (Spec	ify)	
ם	Jing Afte fune	tlon	1 Øvatural 5 ☐ Pending	3	onth, Day Year)	28b. Time o Injury	Worl	yat k? Yes 2. ☐		3d. Describe I	now injur	y occurred		
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2	after i Dire d in b	erti	4 Homicide		ding, etc. (Speci		7,			City or Tov	vn, State)		
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) Certifying 2 Medical E	xeminer: On the	ne best of my kno basis of examina inner stated.	owledge, deat ation and/or in	n occurred at the tin vestigation, in my o	ne, date ar pinion, dea	nd place, ar ath occurre	nd due to the d at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	To the within To the	Me	29b. Signature and title of certifier				29c. License		•		29d. Dat	e signed (Month	. Day, Year)	-
			1 Cathe	~ R	bla.	e m	o neo	1457	90 -		11	15	707	
			30. Name and address of person v	vho completed car	use of death (Iter	m 23a) (Type,	Print)	. 4 .	1		1./	-4		-
	6 813		Carreine 1.0	tomer	mo	1346	5.0:0	17/2	- 51	- Sui	te a	13 Sal.	Ibma, M	D
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0	7 2007	Registrar's Signa	ature	South						25 mg, m	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0.071. Decedent's Name (First, Middle, Last) 2. Date of Death Physician George W. Hawes 2007 November 5:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner College View Center Frederick Frederick 9. Birthplace (State or Foreign Country) Mary Land If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 12, 1920 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M M 2 □ F 214-16-7234 87 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10h County 10c. City. Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at Maryland Frederick Frederick 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8009 Old Receiver Road 21702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 104.0 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1XYes 2 No 1942 - If Yes, Give Year or Dates; 1945 Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ð 3 X Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Animal Care Taker Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Hawes Rosa Riley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Hawes 1722 Heather Lane, Frederick, Maryalnd 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State November injury or Frederick, Maryland Mount Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 16, 2007 Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 21. Signature of Funeral Service Licen M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End Stage Renel Disease **Physician** Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Colonary Artary Disease Years Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a nonsequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9☐Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed

certificate this After t Director: A in by the f

Be

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Medical

3 Suicide

4 Homicide

29b. Signature and title of certification

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 X No

25. Was case referred to medical examiner? Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 X Natural 5 Pending investigation Injury 2 Accident

Other: 4 🛛 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 28d. Describe how injury occurred

1□ Yes

26. Place of Death (Check only one)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

D0062223

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 196 Thomas Johnson Drive, Suite 230, Frederick, MD 21702

29d. Date signed (Month, Day, Year)

November 14, 2007

10 State Registrar

31. Date filed (Month, Day, Year) NOV 2 0 2007

Praveen Bolarum,

6 Could not be determined



DHMH 17 Rev 1/2001

To the Hospital or Attending Physician:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) Month 10/30/2007 **Physician** William Wagner Heintz 6:35 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4701 Bayfields RD. Harwood Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign XXM 2 F (Month, Day, Year 2/29/1908 99 Washington, DC Director 578-05-3982 Usual Residence of Decedent death with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐Yes 2☐No Director MD Anne Arundel Harwood 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4701 Bayfields Rd. 20776 Funeral USA 'natural', or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iter amy Injury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Owner- Operator Lithography 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Frederick Charles Heintz Emma Lillian Wagner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4703 Bayfield Rd. Harwood, MD 20776 Richard Heintz 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ICremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 11/2/2007 Baltimore, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Lightseg 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Right **Physician** 14 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed burial-trar and Due to (or as a consequence of) physician Physician/Medical the as IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2,2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death,

To the Funeral Director: After this certifica

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certified 29c. License number

D38563

29d. Date signed (Month, Day, Year) 12007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bicibaun mo 134 Wayne

wonsville Rd, West Piler

State Registrar

Medical

31. Date filed (Month, Day, Year) NOV 0 2 2007

			1 - State Registrar	•	partment of Health and leartificate of Death	Mental Hygier	ZUUI	37138
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
п	Physicia		George Kenneth Hiles	. Cr			7 2007	4:15 a м
	/Medic Examin		4a. Facility Name (If not institution, give street a		4b. City, Town, or Location of Deat		4c. County of Deal	
			Williamsport Nursing	Home	Williamsport		Washing	ton
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthda)			9. Birt	hplace (State or Foreign
Ш	Director	Ì	201-18-5042 ^{1⊠M 2}	81 Yrs.		Nov. 24		nnsylvania
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	ocation			10d. Inside City Limits
	eho	ō						11√∑Yes 2 □ No
	28a-1	Director	Maryland Washington 10e. Street and Number	Hag	erstown 10f. Zip Code	10a.	Citizen of What Co	ountry?
	with			4 0				•
	eath	Funerai	19 N. Locust Street 11. Marital Status 12. Wa		21740 . Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame	
	ritten	Ξ	Ап	ned Forces? ∃Yes 2 X No	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, Whit	
036	urs a	þ	If Y	es, Give ar or Dates:	1 ☐ Yes 2 X No Specify:		Specify: W	hite
Ō	within 72 hours after death with the Maryland ene. then "neturel", or iteme 23e or 28e-f ehow he Medical Exarti mir must be multied at	Completed	15. Decedent's Education (Specify only highest grade comp	16a. Dec	edent's Usual Occupation	ding.	Kind of Business	Industry
21	thin 7	pje		llege (1-4or 5+)	re kind of work done during most of wo DO NOT use retired)	, Amig		
2	ed wi	Co	4	0	Farmer		Farming	
p	tal H d oth	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, Maid	len Sumame)	
<u>y</u> la	ould Men Marke	으	Elmer Hiles			rice Imes		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 le marked other then "neturel", or iteme 23e or 28e-f ehow appringury or other treumatic event, the Modical Examinating the notified at an app.e.		19a. Informant's Name/Relationship (Type, Pri		iling Address (Street and Number or Ri			11
	tealthealthealthealthealthealthealthealt		Beatrice McGowan - D	Daughter 731	Jefferson Boulev		Stown Mo Location - City or	
Baltimore,	ges it of h		1 ☐ Burial 2 🎇 Cremation 3 ☐ Remova	al from State cemetery, cr	ematory or other place)	4		
ţ	t. Partmer rtant riury	- 3	4 Donation 5 Other (Specify)		own Crematory 11/ 22. Name and Address of Facility		. 4-4	, Maryland
Bal	Depermine Depermine Important in processing processing in		21. Signature of Funeral Service Licensee			Minnich l		
			23a. Part1. Enter the disease, or complication:		415 E. Wilson Blv		own, Mu.	Approximate
			shock, or heart failure. List only one cause Immediate Cause (Final	se on each line.	mor mode or syring, sacri de sardia	o o. 100p.ia(o.) aoo(Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Preumonia				1 day
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8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai	d					
9	ing pl	Med	IF FEMALE:			-10 101	Marie Comment	
Вох	leath certific attending p I for use as	ian/	23b. Was decedent pregnant in the past 12 months?		☐Ectopic pregnancy		23d. Date of de Month	livery Day Year
<u>.</u>	the a	Completed by Physician/Me	1 Vas 2 No	□Pregnant at time of death 5 □Unknown	Other (specify)			
٥.	wrequires thet the de been signed by the should be detached	Ph	Part II. Other significant conditions contributi	ng to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
ds,	uires sign Id be	d b	Seizure Disorder			1 ☐ Yes	212No 3□P	robably 4 Unknown
COL	w req beer shou	iete	· .	beinger Ties		24a. Was an	24b. Were a	utopsy findings available
Re	eician: The law certificete has t lirector, page 2 s	E P	Demention of A13	heimers Type	<u> </u>	autopsy performed	? prior to death?	completion of cause of
ta	ifficet or. pe		25. Was case referred to medical		26 Place of De	1 ☐ Yes 2 ☐ ath Check only one	No I Tes	2 □ No
>	Phyeician: r this certific ral director.	To Be	examiner? 1 Yes 2 No Hospita	al: 1 ☐ Inpatient 2 ☐ ER/Outpati	1 000	Home 5 ☐ Residence	6 □Other (Spe	ocify)
0	g Ph er th			Date of Injury (Month, Day Year) 28b. Time	of 28c. Injury at	28d. Describe how it		
jo	Attending r death. ector: After by the fune	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(M 1 ☐ Yes 2 ☐ No			
Division of Vital Records, P.O.	r Atte ter de irecte irecte	Certification:	3 Suicide 6 Could not be determined 28e	 Place of Injury - At home, farm, building, etc. (Specify) 	street, factory, office	28f. Location (Street City or Town, St		ural Route Number,
٥	To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page							
	Hosp 14 hot Fune Fely fi	icai	(Check only 2 Medical Examiner: O	in the basis of examination and/or	ath occurred at the time, date and plac investigation, in my opinion, death occ			
	To the Hospital within 24 hours e To the Funerel I completely filled	Medicai	one) ar 29b. Signature and title of certifier	nd manner stated.	29c. License number	29d.	Date signed (Mon	th, Day, Year)
	S 1 2 1		Dantria Kuttra	4- Sands No	047451			Ann a
			30. Name and address of nerson who complete	ed cause of death (Item 23a) (Tim				
٢	1-40		Cynthia Kuther-Sano	Is no Williamspo	ort Nursing Home,	Williams	ort Mas	Hant 21795
	Sta	te	30. Name and address of person who complete Cynthia Kuther-Sano 31. Date filed (Month Day Year) 2007	32. Registrar's Signature	1. 11.			100
	Regist		MAA A o 5001	A Marie St. A.	13 ZAGRA			

			1 - State Amend #5 Per	State of Maryla FH G875 1/1	and / Depa L 0/08	artmer <i>Hifica</i> i	nt of Healt e of Dea	th and M	-	giene Reg. No.	1007	37139	
			Decedent's Name (First, Middle, Last) 2. Date of Death									3. Time of Death	
	Physici /Medic		Natalie Elizabeth	Hoover					r 4		4:15 P ^M	(
	Examin		4a. Facility Name (If not institution, give :	street and number)		4b. City	Town, or Locati	tion of Death		T	County of Deal		
1			Montgomery General	Hospital		01ne	У			Mo	ontgome	cv	
6-	Funeral		5. Social Security Number 6. Sec. 7925	IM alX E	rs. last birthday)	If Unde Months		nder 24 Hrs. urs Min.	8. Date of Birt (Month, Da	h	9. Bird	hplace (State or Foreigr	7
(g)	Director		219-36-1 925	6	7 Yrs.				Jan. 1	0, 1	940 Mar	yland	
	and and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				,		10d. Inside City Limits	
	Marylan f ehow led at	ō	Manus 1 and 1 Manus and 2	Co	ithorah.	. 30 0						1 ☐ Yes 2 📉 No	,
	the 28a	Director	Maryland Montgomer	y Ga.	ithersbu		Code			10g. Citi	izen of What Co	ountry?	
	3a or		24908 Woodfield Sch	ool Pond		208				TTCA			
	death ms 2	Funerai		12. Was Decedent Ever in		Was Dece	dent of Hispanic	Origin? (Spe	cify Yes or No	USA	14. Race - Ame		
9	after or ite	Ē	1 ☐ Never Married 2 🕅 Married	Armed Forces? 1 ☐ Yes 2 🗶 No			cify Cuban, Mex		Hican, etc.)		Black, Whit	e, etc.	
ဗ္ဗ	ours iral',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2∭ No Spec	icny.			Specify: Wh	ite	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene sther than "natural", or items 23s or 28s-f show ent, its Medical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation e <i>completed)</i>	(Give	kind of we	al Occupation ork done during r	most of worki	ng	16b. Ki	ind of Business	Industry	
2	within ne hen	mp	Elementary/Secondary (0-12)	College (1-4or 5+)			se retired)						
7	Hygie Hygie ther t		12 17. Father's Name (First, Middle, Last)		Bookke	eeper		tother's Name	(First, Middle,			y Business	
anc	o d ia	Be											
Ž	2 should be filed within 72 hours after death with the Maryla and Mental tygener and Mental tygener is marked other then "natural", or itema 23e or 28e-f ehow aumatic event, the Modical Examinar must be notified at	2	Lloyd Sanderson Ste 19a. Informant's Name/Relationship (Ty		19b Mailir	na Addres				n Mahoney Der, City or Town, State, Zip Code)			
<u>8</u>	ges 1 and 2 should t of Health and Men if item 27 is marke or other traumatic					•							^
ē,	Heal Heal tem 2		David W. Hoover, ht		D. Place of Disponden	sition (Na	me of	SCHOOL	Road,	20c. Lo	nersbur ocation - City or	g, MD 2088 Town, State	4
<u>o</u>	ages ont of it: if i		1 ☐ Burial 2 【X Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Special)	lemoval mom State				111					
altimore,	artme ortan injur	11	21 ign-ture of uneral/Serv Licens	e M	etropol:	LCan 2. Name a	Cremato nd Address of Fa	acility Mal	6/200/	Alex	kandria	, Virginia Tuneral Homo	_
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	- 176		23a. Palt1. Enter the disease, or compli	cations that caused the de							rryrand	Approximate Interval Between	
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			disease or condition resulting in death)	Due to (or as a cons	-	гс те	ukemia					Years	-
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8760,	rate be executed hysician and the burial-transit		Todakii g iii dodkii j Eddi	Due to (or as a cons	equence or):								
	the the	dicai		1.									_
9 ×	death certific e attending p id for use as i	Physician/Me	IF FEMALE:	3c. If yes, outcome of pred	nancy						Ood Date of de		
Вох	atten for u	cian	in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time o	etal death 3[Ectopic p				23d. Date of delivery Month Day Year			
o.	0 0 0	ysi	1 ☐ Yes 2 🔯 No 9 ☐ Unknown										
<u> </u>	The law requires that the te has been signed by th bage 2 should be detached.		Part II. Other significant conditions cor	ntributing to death but not r	art I.	23e. Did to	obacco u	the cause of death?					
<u>5</u>	w require been sig should b	Completed by	Sepsic Shock						10	res 2	s 2 XNo 3 Probably 4 Unknown		
၀	s bee	ojet							24a. Was		24b. Were au	itopsy findings available	3
æ	The lay	E								osy rmed? 2 X No	death?	completion of cause of 2 □ No	
<u>ra</u>		a	25. Was case referred to medical				26. P	Place of Death	(Check only o		10.103	2010	
>	Physic this ce at direc	To B	examiner? 1 ☐ Yes 2 📉 No	lospital: 1 💢 Inpatient 2	☐ ER/Outpatier	nt 3 🗆 D	Other						
0	Attending Physician: It death. ector: After this certific. by the funeral director.		27. Manner of Death 1 XNatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	f	28c. Injury at Work?		28d. Describe I				
Sio	ittendi death. ctor: A the fu	cati	2 Accident investigation			М	1 Tes 2						
Division of Vital Records,	i or Atten after deat Director: I in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, str ocify)	reet, factor	y, office	2	28f. Location (S City or Tox	Street an vn, State	id Number or Ri i)	ural Route Number,	
			170 0 171 1 170										
	Mospita 24 hours Funeral etely filled	edical	29a. Certifier 1 X Certifying Physics (Check only 2 Medical Examination)	sician: To the best of my kner: On the basis of examinand manner stated.	mowledge, death ination and/or in	h occurred vestigation	at the time, date i, in my opinion,	e and place, a death occurre	and due to the ed at the time,	cause(s) date and) and manner a: d place, and due	s stated. It to the cause(s)	
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifier	and mariner stated.		29	c. License numb	ber		29d. Dat	te signed (Mont	h. Day, Year)	_
	⊢≯⊢ŏ		I Chit Res	6.11									
	_		30. Name and address of person who co	mpleted cause of death (II	tem 23a) (Tyne		2452		N	lover	mber 5,	2007	_
1	1			1/			n Dester-	. #227	0.1	3.	1	20832	
· ·	Sta	te	Chitra Raja Lopal, 31. Date filed (Month, Day, Year) NOV 0 7 20	32. Registrar's Sig	mature	ede	p brive	2, #3 <u>2</u> /	, Ulne	у , М	aryland	20032	
	Registr	ar	NOV 0 7 20	UI BROWN	10. 10								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200

		1	For State of Maryland / L State Registrar	Department of Health and Ment Certificate of Death	Reg. No. 200	7 37140					
	Physicia		1. Decedent's Name (First, Middle, Last) HERBERT S. JONE		ate of Death Month Day Year O 28 07	3. Time of Death					
- 3	/Medic	al	Aa. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Deat						
	Examin	er '	701 Glenwood St. Apt 601	Annapolis	Anne Ar						
	Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last bir</i> 218-42-8246 5.	Yrs. If Under 1 Year If Under 24 Hrs. Annual Months Days Hours Min. Fee	Month, Day, Year) Co.	nplace (State or Foreign untry) Yland					
	and t	-	Usual Residence of Decedent 10c. City, Tow 10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits					
	A-f sho	io	Maryland Anne Arundel Anna	apolis		1X□Yes 2□No					
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	untry?					
	eath v	Funeral	701 Glenwood St. Apt 601 11. Marital Status 12. Was Decedent Ever in U.S.	21401 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	USA Yes or No- n, etc.) 14. Race - Ame Black, White						
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	Specify: B	Lack					
Maryland 21215-0036	72 ho 'natur dical E	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)	16b. Kind of Business/	Industry					
121	within iene. than the Me	dwo	Elementary/Secondary (0-12) College (1-4or 5+) 12th 0	Truck Driver	Chaney Er	nterprise					
<u>م</u>	e filed al Hygi other vent, t	Be Co	17. Father's Name (First, Middle, Last)		st, Middle, Maiden Surname)	-					
ylar	should be I and Mental s marked o umatic eve	Jo.	John Jones Sr.	Pearline D. Mailing Address (Street and Number or Rural Ro							
Mar	d 2 sh th and t7 is m traum		Tod. Information (197)	45 O'Berry Ct. Anna							
	s 1 and 2 if Health item 27 i	ŀ	20a. Method of Disposition 20b Place of	f Disposition (Name of Date	20c. Location - City or	Town, State					
<u><u>E</u></u>	Pages ment of f ant: If ite ury or of		4 Donation & Bother (Speelly)	rial Park 11-2-0	do						
Baltimore,	permit. P Departm Importar any injur		21. Signature of Funeral Service Licensee Fary D. Reese M00483	Wanname Reduces of Secilic Ons N 821 West St. Anna	polis, Md. 214	101					
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac or re	spiratory arrest,	Approximate Interval Between Onset and Death					
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence			6 mos					
8	Examiner			RADIATION Lu	NG CA	117 _					
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
o Î	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	of);							
68760,	ate be	dical	d								
.O. Box 6	death certifi e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown	th 3□Ectopic pregnancy 5□ Other (specify)	23d. Date of de Month	elivery Day Year					
Δ.	requires that the een signed by th hould be detache	by	1. ✓ Yes 2 □ No 3 □								
Records,	e law has b je 2 sl	Completed			autopsy prior to performed? peath?	autopsy findings available completion of cause of					
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (C		- 476.3					
or	Phys r this ral dir	٠ <u>.</u>	27. Manner of Death 28a. Date of Injury 28b	Time of 28c. Injury at 28d	5 Residence 6 □Other (Sp. Describe how injury occurred	есіту)					
ion	Attending Prrdeath. cctor: After the type the funeral	ation	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	M 1 ☐ Yes 2 ☐ No							
Division or Vital	al or Atte s after dea al Directo	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	,	Location (Street and Number or I City or Town, State)						
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ledical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occurred	at the time, date and place, and d	ue to the cause(s)					
	To th withir To th	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo						
	36	D'	30. Name and address of person who completed cause of death (Item 23a MICHARL J.Ca/ENA Wr 455	a) (Type, Print)	Awarpolis,	ND 21401					
	St Regist	ate rar	31. Date filled (Month, Day, Year) NOV 0 5 2007	DeFewse Highway	(weither /						

			1 - For State Registrar	State of M	laryland /	-	artment <i>tificate</i>					giene Reg. Na 2007	7 37141		
100	Physici	an	1. Decedent's Name (First, Middle, Last,)						2	Date of Dea Month	ith Day Yea	3. Time of Death		
	/Medi	cal	Edward Martin Jo 4a. Facility Name (If not institution, give		45 0%	F			ovembe	r 4 , 2007 4c. County of De	3:45A M				
	Examir	ner	12750 Sh1age1 Ro	Wa	1dor				Charle	!S					
#	Funeral Director			7. A	ge (In yrs. last 61	birthday). Yrs.	If Under Months	1 Year Days	If Under Hours	Min. O	Date of Birth	25,1946 W	inthplace (State or Foreign ashington, DC		
	and		Usuat Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation						10d. Inside City Limits		
	Mary Feb	tor	Maryland Charles							1 ☐ Yes 2 👿 No					
	h with the	Funeral Director	10e. Street and Number 12750 Shlagel Rd.					Code 0601			10g. Citizen of What	Citizen of What Country?			
9036	be filed within 72 hours after death with the Maryland stal Hygiene. Ind hygiene. Indicate than "naturel", or Itema 23e or 28e-f ehow event, I'na Madical Examinar must be notified at	by	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	t Ever in U.S. ? No	1	Vas Deced Yes, spec	fy Cubar	spanic Ori n, Mexicar Specify:	n, Puerto Ri	fy Yes or No- can, etc.)	Black, W	nerican Indian, hite, etc. hite			
1215-	within 72 then.	Completed	(Specify only highest grade completed) (Given Elementary/Secondary (0-12) College (1-4or 5+)					l Occupa k done d e retired) r	rovement						
Maryland 21215-0036	ould be filed v Mental Hygie arked other t atic event, to	To Be Co	9 17. Father's Name (First, Middle, Last) Edward Jones								First, Middle,	Maiden Sumame)			
Mary	d 2 sho th and 7 is m traum	-	19a. Informant's Name/Relationship (Ty Janice Jones/Wife	pe, Print)	4.0		-		and Numbe	er or Rural F	Route Numbe	r, City or Town, State 20601	, Zip Code)		
Baltimore,	ages 1 and 2 nt of Health t: If item 27 i		20a. Method of Discosition 1	lemoval from State	20b. Place	at Dispos	sition (Nam	ne of	1	ovembe	er 6,	20c. Location - City			
Baltin	permit. Pages 1 an Department of Heali Important: If item 2 eny injury or other once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	Olto	-mos	22	. Name and	d Addres	s of Facilit		sfield-	Charlotte Echols F.			
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as	d the death. Edine.	onot ente	er the mode	of dying	, such as	cardiac or r		rest,	Approximate Interval Between Onset and Death		
8760,	icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		s a consequent	quence af):									
P.O. Box 6	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal dea	ath 3 🗌	Ectopic pre Other (spe					23d. Date of o Month	delivery Day Year		
ords, P	w requires that been signed b should be det	a final significant conditions continuous to the final resulting in the indeptying cause given in Part 1.									to the cause of death? Probably 4 □Unknown				
Division of Vital Records,	n: The law icate has b r. page 2 s	E CHRONIC DISTREVETS VILMONING PISENS									24a. Was a autops perfor 1 Yes	sy prior t med?, death	autopsy findings available o completion of cause of ? es 2 \(\subseteq\) No		
Ž	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospitat:	oot affeb	Outpation	200.00	Othe			Check only or	1			
on of	nding Phy th. : After this s funeral c	tion: To	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No						28	g Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred				
Divis	Hospital or Attending 24 hours after death. Funeral Director: Afte tely filled in by the fune	Certification:	3 Suicide 6 Could not be determined							281. Location (Street and Number or Rural Route Number. City or Town, State)					
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best on the basis of and manner st	of examination	dge, death and/or inv	occurred a restigation,	it the tim	e, date and inion, deal	d place, and th occurred	d due to the c at the time, d	ause(s) and manner late and place, and d	as stated. ue to the cause(s)		
)	To the within 2 To the complete	M	29b. Signature and title of certifier	4				License D4:	number	9	2	29d. Date signed (Mc	2007		
4	Pola		30. Name and address of person who co	mpleted cause of h, Old L	death (Item 23:	a) (Type, !	Print) Walde	orf,	MD				(
	Sta Registr		31. Date filed (Month, Day, Year)	20 %	rar's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ,25 PM Anita Marie Rose Jardina November 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days 1 ☐ M 2 🛣 42 207-60-4687 Pennsylvania 1965 June 14 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22218 Troy Lane 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 24 Married 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Software Company Ouality Assurance Coordinator Δ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence E. Custer Rose ဥ Harry Gene Roase 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 22218 Troy Lane Hagerstown Maryland 21742 Dino Matthew Jardina - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important; If Ite any Injury or ot 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 11-12-2007 Davidsville PA 15928 Countryside Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licens 1331 Eastern Blvd. N. Hagerstown Maryland 21742 autti complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-tran and Due to (or as a consequence of) signed by the attending physician is be detached for use as the burial by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed Be Certification: To

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requir within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should

Baltimore, Maryland 21215-0036

										24a. Was an autopsy performed?∕ 1∐ Yes 2 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
25. Was case refer		red to medical	26. Place of Death (Check only one)											
	examiner? 1 ☐ Yes 2 ☐	No	Hospital	12 Inpatient 2[Other (Specify)									
1 ☑ Nat 2 ☐ Acc 3 ☐ Su	Manner of Death 1 ☑ Natural 2 ☐ Accident	n 5		. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c	. Injury at Work? 1 □ Yes 2 □ No	280	d. Describe how injury	occurred			
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		Place of injury - At building, etc. (Spec	home, farm, stree	et, fact	ory, o	ffice	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
298	a. Certifier (Check only one)		miner: Q								and manner as stated. place, and due to the cause(s)			

29c. License numbe

362

29d. Date signed/(Month, Day, Year)

7101

State

s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addi

erson Blud 32. Registrar's Signature

31. Date filed (Month, Day (ear)

29b. Signature and title of cer

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Vear Henrietta Ruth Jones November 6 2007 12:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Williamsport Washington Homewood Retirement Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2(XF Hours 16,1913 **Director** 174-38-9759 94 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 23s or 28a-f shov any fujury or other traumatic event, the Medica Examiner must be notified at any fujury or other traumatic event, the Medica Examiner must be notified at 1 ☐ Yes 2 X No Directo Williamsport Maryland Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16505 Virginia Avenue USA 21795 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles S. Peters 2 Smeal Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Bulow - Daughter 16605 Mosby Drive Williamsport, Maryland 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 Other (Specify) Forest Lawn Cem. Nov.10,2007 Johnstown, Pennsylvania 21. Signature of Juneral S O'S Berne After the Failty Home, P.A. 21795 425 S. Conococheague St.Williamsport, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue to for as a consequence of: Examiner Due to (or as a consequence of): P.O. Box 68760 Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2E No 3 Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certified 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA P 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one) 29b. Signature and title of State NOV 0 Ü Registrar

	_		For State Registrar 1. Decedent's Name (First, Middle		f Maryland		artment rtificate			and M	,	Reg. No.	2007	3. Time of	Death 4
	Physici		James Vincent K						Month 10/2	27/07	Day Year				
	/Medic Examir		4a. Facility Name (If not institution 3418 London Lea		nber)		4b. City, To	own, or Laur		of Death	· · ·	4c. County of Death Anne Arundel			
5 (Funeral Director		5. Social Security Number 578-60-7688 Usual Residence of Decedent	If Under 1 Months	Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day 1/15/1	Birth 9. Birthplace (State or Foreign Country) 71947 Washington, DC						
	yland sow		10a. State 10b. County		10c. City,	Town or Lo	cation						10	od. Inside City	Limits
	e Mar 3a-f sh tiffied	Director	MD Anne A	Arundel	I	_aure]	_							1 🗌 Yes	No <u>Fi</u>
	with th		10e. Street and Number		10f. Zip C					10g. Citize	en of What Coun	try?			
	ns 23a	Funeral	3418 London Lea	12. Was Dece	dent Ever in U.S.	13. \		2072		ain? (Spe	cify Yes or No-	14	USA 4. Race - America	an Indian,	
٥	after o		MXNever Married 2 ☐ Marr	ied Armed For 1 Yes If Yes, Giv Year or Da	rces?		fYes, specif 1 □ Yes 1x1		n, Mexican Specify:	, Puèrto I	cify Yes or No- Rican, etc.)		Black, White, 6		
2-0036	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	d by	3 Widowed 4 Divorced										specify.		
-612	in 72 l	Completed	15. Deceden (Specify only higher	st grade completed)		(Give life. I	dent's Usual kind of work DO NOT use	done de retired	ation Iuring most)	of working	ng	16b. Kini	d of Business/Ind	lustry	
717	d with giene.	mo	Elementary/Secondary (0-12)	College (1 5+	-4or 5+)							Libra	ary of C	ongres	s
yland	be file tal Hy d othe event,	Be	17. Father's Name (First, Middle,	•							(First, Middle,		Gurname)	-	
<u>ya</u>	d Men narke	ျ	James V. Kenned			10h Mailir	a Address /	(Ctract o			Harney		Town, State, Zip		
Z Z	nd 2 sh lith and 27 Is n r traun		Denise White	Cousin			Sherb				ings, M			Code)	
animore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐Removal from S			sition (Name matory or oth			1/1/	2007 B		ation - City or To		
Dair	permit. Departri Importa any Inju		21. Signature of the Service	Licensee	,	22	2. Name and L2 Rid	Addres	s of Facility Ave	Har	desty F nnapoli	uner s, M	al Home, D 21401	P.A.	-
ှ မူ	Oentificate be executed /Medical Examine physician and size as the purial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	or as a consequent	nce of):	eroti	1 C		CAI	rt]	156	ease	Approximate Interval Betwo Onset and Di	
O. Box 68	death certific e attending p d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	/as decedent pregnant i the past 12 months? ☐ Yes 2☐ No 23c. If yes, outcome pt pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pr 4☐ Pregnant at time of death 5☐ Other (sp							23d. Date of delivery Month Day Year				ear
cords, r.	requires that the een signed by thi nould be detache	by	Part II. Other significant condition										pacco use contribute to the cause of death?		
Ťi –	2 5	Completed	24a. Was a autop: perfor								sy				
III	cian: ertifica ctor, p	BeC	25. Was case referred to medica examiner?							of Death	(Check only or		7		
5	Physic this c	은	Yes 2 No Prospital, 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other										<i>'</i>)		
Sion	ding th. : After e funel	tion	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	g (Mont	th, Day Year)	Injury	M	lc. Injury Work 1 □ \	y at 28d. Describe how injury occurred ?? Yes 2 □ No						
DIVIS	al or Atter s after dea if Director ed in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Town, State)								l Route Numb	er,			
	To the Hospital or Attending Physician: The I within E4 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)	ng Physician: To the Examiner: On the ba and mann	asis of examinatio	edge, deatl on and/or in	n occurred a vestigation, i	it the tim	ne, date an pinion, dea	d place, a	and due to the ded at the time, d	cause(s) a date and p	and manner as st place, and due to	ated. the cause(s)	
	Withi To t	Ž	29b. Signature and title of certifie		De	put	1 29c.	License	number	- , ,	- 1		signed (Month, I		
			Mulle	m Py	it.	mo	7	000	609	4		- 1	10/291	17	
4	5		30. Name and address of person		e of death (Item 2	3a) (Type,	Print) 695	- K	Fmx	211	2.4		21035	_	
À	Sta Registr		31. Date filed (Month, Day, Year)		Sistrar's Signatur	re //	berle	ر ر		, , ,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17:30 RM **Physician** 1, 2007 Olive C. Knowles November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 235 Arbour Drive North East Cecil if Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕅 F 86 July 31, 1921 Maryland Director 214-18-0959 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No 28a-f sh notified Cecil Director Maryland North East 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code De or 21901 "natural", or items 23a 235 Arbour Drive United States Funeral death 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 Is marked other the any injury or other traumatic event, the lonce. 10 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elisha Atkinson Junietta DeHaven ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21901 Kimberly Olah / Granddaughter 35 Arbour Drive, North East, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Hart's Cemetery 6, 2007 4 ☐ Donation 5 ☐ Other (Specify) Elk Neck, Maryland 21. Signature Funeral vic Licens 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nte /Medical ue to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequency of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) I □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 2 RN 1□ Yes 1 Yes 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Pesidence 6 ☐ Other (Specify) 1 Tes 2 1 Ho 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2

State Registrar and address of person who complete

31. Date filed (Month, Day,

ILAL

2007

Year)

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Ca

35ink

d cause of death (Item 23a) (Type, Print)

-mi)

7EL

32. Registrar's Signature

Day

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

11-8-07

Year

Physician /Medical Examiner

permit. Pages 1 Department of H Important: If ite any Injury or ot

Physician

/Medical

Examiner

10a. State

Funeral

Director

show

er than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at

death 1

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iten

Baltimore, Maryland 21215-0036

Completed by Funeral

Be ဥ

sician and burial-transit physician s the burial Physician/Medical attending p been signed by the should be detached Completed by director, Be 2

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

Examine Certification: 29a. Certifier Medical

5 Pending investigation

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRAHZ

1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

29b. Signature and title of certifier

7 anjour

31. Date filed (Month

Monter

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Altruordend Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 🗀 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ♣ No 24a. Was an autopsy performer 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

🖒 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

null street Hagerstown.

29c. License number

D28365

(Month, Day Year)

368

32. Régistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Leo Francis Komorowski, Sr NOV 11:10 02 /Medical 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 194-22-4141 Director 1929 Pennsylvania Sept Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene.
n 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10h County 'natural", or items 23a or 28a-f show dical Examiner must be notified at 1 XYes 2 ☐ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21740 30 Redwood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Xyes 2 No 8 / 2 2 / 4 6
If Yes, Give 9 / 5 / 7 0 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 8/5/49 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Manufacture Machinist 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Josephine Krzyston Komorowski Frank Komorowski ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any Injury or other tra Joan H. Komorowski - wi|fe 30 Redwood Drive Hagerstown Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-6-2007 Hagersotwn Maryland Rest Haven Cemetery 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd, N. Hagersotwn Maryland 21742 23a. Part1. Enter the disease, or com/lifations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Adenecarinoma Hans /Medical Due to (or as a consequence of). Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death Day in the past 12 months? Month Vear 4□Pregnant at time of death 5 ☐ Other (specify) I□Yes 2 □ No ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Be Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy performed? death? 1 ☐ Yes 2 □ No 1□ Yes 2 **- N** 25. Was case referred to predical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

SH-7+1

State Registrar 30. Name and address of perseo

NOV

2007

31. Date filed (Month, Day,

(Type, Print)

of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11 2007 1625 KENNELL ELIZABETH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CUMBERLAND ALLEGANY WMHS-BRADDOCK CAMPUS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-8-1920 9. Birthplace (State or Foreign Country)
PA 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours 1 □ M 2 X F Director 180 50 1983 filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Wellersburg Somerset PA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 15564 15090 Main St. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify:White altimore, Maryland 21215-0036 Specify. þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maude Beall James T. Gomer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda L. Kennell/Daughter 15090 Main St., Wellersburg, PA 15564 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 ■ Removal from State 4 □ Donation 5 □ Other (Specify) 11-6-2007 Meyersdale, PA Oaks Cem. White 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harvey H. Zeigler Funeral Home 169 Clarence St. Hyndman PA 15545 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Du to (or as a consequence of): Examiner Equantially list on official, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. death certificate be Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tyes 2 No 3 Probably 4- Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 ☐ Yes perform 2 No 2 2 No 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death Check onl one Be Other: 1 Tes 2 No 2 ER/Outpatient 3 DOA ို 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: within 24 hours after death.

To the Funeral Director: After completely filled in by the funera 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, Hospital or Attending Physician:

the

4 noss State

Registrar

Medical

29b. Signature and title of certifie

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rive, Cumberland, MD 21502 zaman

31. Date filed (Month, Day, Year) NOV 05 2007

29a. Certifier

(Check only one)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month November 3, 2007 **Physician** Mariano Ρ. Leuterio 1:09 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Ft. Washington Ft. Washington Hospital 7. Age (In yrs. last birthday) 1/4 Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 25, 1928 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** China 223-21-3833 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Fort Washington 1 Yes 2 No Maryland Prince George's Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 20744 99 Swan Creek Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: 1 Never Married 2 X Married Specify: Asian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Engineering Firm Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leuterio Ricardo Shizuko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 99 Swan Creek Rd., Ft. Washington, MD 20744 Corazon M. Leuterio - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery 11/9/2007 Silver Spring, MD 20a. Method of Disposition X⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part1. Enter the disease, or complications that caused the diah. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Meumonia **Physician** /Medical Due to (or as a consequence of) metastatic prostate cancer Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by abetes Mellitus 2 1 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed2 certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 1 7 es 2 No Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 2 ER/Outpatient 3□ DOA this Director: After that in by the funeral 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification; 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) D46741 November 3, 2007 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) leepak Dachdeva M.D. 11711 Livingston Rd., Ft. Washington, MD 20744 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State 5 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2007 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician October 30, 2007 4:24 \mathbf{P} M Thelma Coral Lawson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel **Annapolis** Anne Arundel Medical Center 8. Date of Birth (Month, Day, Year)

June 29, 1920 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 □ M 2 X X Yrs. California 87 **Director** 567-05-4905 Usual Residence of Decedent 10d. Inside City Limits 3a or 28a-f show t be notified at 10c. City, Town or Location 1 ☐ Yes XXXIX Director **Vallejo** Solano California 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 94590 "natural", or items 23a 63 D Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☐ No If Yes, GiveXX Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify. White Ş Q 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) State of California Dept. of Employment and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Rachel Meeske Calvin Willis Bagg ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 Is
any injury or other trau 103 Paseo Arboles Fairfield California 94534 Carole A. Paterson / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 11/2/2007 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee mille 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonary
Due to (or as a consequence 1): 1 hour **Physician** /Medical Examiner kep venous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last to for as a consequence of the Examiner burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ş 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of performed? Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident spital or Attendiours after death. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral C Hospital 1 eritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of complier 29c. License number 10/31/07 DOO 62964 Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway Annapolis, Md. 21401 2001 Medical State

DHMH 17 Rev 1/2001

Registrar

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Amend Item# 5 11/08/\$Tate of Maryland / Department of Health and Mental Hygiene Cecil Co. Health Dept Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4, November 2007 11:23 pM Melody Ann Lamb /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 159 North Main Street Port Deposit 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday **Funeral** Days 1 □ M 2 🛛 F Months Hours 213-58-3 June 10, 1951 Director 56 Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a, State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 √ Yes 2 No Director Maryland Cecil Port Deposit 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 159 North Main Street 21904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑MNo Specify. 9 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence Twelve Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental is marked Ralph Sylvester Staubs Alma Eileen Ways ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Darrel A. Fritsche P.O. Box 396, Fallston, Maryland injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State R.A. Ferris & Co., Inc. West Chester, Pennsylvania 11/06/07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 23d. Date of delivery 3 ☐Ectopic pregnancy signed by the atter Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown should Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2X No 24a. Was an autopsy perform page certificate 2**K**] No 1□ Yes the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ☐ Nursing Home 5 【 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No M after death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examination the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely nd manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig 0 0063981 2007 MO 30 Hame and address of person who completed cause of death (Item 23a) (Type, Print) Revolution St. Havre de Grace 21078 MD 669 Devianin Lee, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 6 2007 Registrar

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LAWSON, SHARON G. Baltimore, Maryland 21215-0036

			For State ame: Registrar					delible Ink artment of I DH ruficate of			-		_	0715	
	Physici /Medi		1. Decedent's Name (Fi	irst, Middle, La							Date of De Month		2001	3.4 iml of beam 7 4:40 P M	
	Examir Funeral		4a. Facility Name (If not THE LION 5. Social Security Numb 232-74-445	S CENTI	ER		rs. last birthday) Yrs.	4b. City, Town, CUMBE If Under 1 Year Months Days	RLAND	24 Hrs. 8	Date of Bi (Month, Di	rth ay, Year)	Cc		
	Director wow ter	_	Usual Residence of Dec 10a. State 10	b. County		10c.	City, Town or Lo			5	EPI.	20,1:	947 19	10d. Inside City Limit	
	with the Ma 3a or 28a-f s t be notified	I Director	WV 10e. Street and Number ROUTE 3,				RIDGEL	10f. Zip Code 2675	3				zen of What Co	1 □ Yes 2 X No ountry?	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □	2 X Married	12. Was Dec	2 X No ive		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2X No	ban, Mexican	gin? (Specil n, Puerto Ric	y Yes or No	0-	14. Race - Ame Black, Whit Specify: WI		
Maryland 21215-0036	filed within 72 hat hat hat the than "natu the than "natu the the hat the hat the hedical out, the hedical the hed	Completed	15. (Specify of Elementary/Secondar	Decedent's Econly highest gra ry (0-12)	de completed)	(1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire PERVISOR	during most ed)	n most of working			nd of Business, LY-SPRI E COMPA	NGFIELD	
yiana	should be file ind Mental Hy s marked othe umatic event,	17. Father's Name (First, Middle, Last) LAWRENCE CARTER WEAVER 18. Mother's Name (First, Middle, M OPAL CLARK													
	and 2 sho lealth and I m 27 Is ma her trauma		Birty H. WILLIAM I	AWSON ,				UTE 3, B	et and Number or Rural Route Number, City or Town, BOX 390, RIDGELEY, WV Date 20c. Location				v 2675	267 53	
Baltimore,	permit. Pages 1 a Department of Hee Important: If Item any injury or othe		20a. Method of Disposit 1 ☑ Burial 2 □ Ci 4 □ Donation 5 □ 21. Signature of Funera	remation 3 C	y)	State	ABE CEM	matory or other pl	1	1/06/	2007	R	IDGELEY		
, no	Physician /Medical Examiner burial-transit	al Examiner	shock, or heart fa Immediate Cause (Fina disease or condition resulting in death) Sequentially list conditi ii any, leading to imme- cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last	dons, diate ng	b. Due to	(or as a cons	sequence of):	peraule	2 Me	ningu	DINA			Interval Between Onset and Death YEALS	
O. DOX 007	The law requires that the death certificate to the sas been signed by the attending physicage 2 should be detached for use as the total safe.	Physician/Medical	IF FEMALE: 23b. Was decedent prein the past 12 moi 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nths?		birth 2 □ F mant at time	Fetal death 3[□Ectopic pregnan □ Other (specify)	су			2	23d. Date of de Month	livery Day Year	
ords, P.O.	w requires that is been signed by should be detain	by	Part II. Other significan	nt conditions	contributing to	death but not	resulting in the u	nderlying cause g	iven in Part I.					o the cause of death?	
Hecc	sician: The law re certificate has be irector, page 2 sho	Completed									24a. Wa: auto per 1 Yes	opsy formed?	prior to death?	utopsy findings availab completion of cause of s 2 No	
Division or vital Records,	ding Phy I. After this funeral d	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No					ther: 4 Nu ury at ork? Yes 2	No 28	5 Res	sidence (how injur	d Number or Fi	ecify) ural Route Number,		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 one)	Medical Exa	miner: On the			th occurred at the ovestigation, in my	opinion, dea			e, date and	d place, and du	e to the cause(s)	
ļ	To To To Com	×	29b. Signature and title	tumo	Strai	liv	M)	D	463		,,,,,,		•	2-200	
	Nf.D St	ate	30. Name and address LUMC Sho 31. Date filed (Month, I	Day, Year)) -62	1/2	nt Aux		nberle	art,	MD)	1502		
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Registrar DHMH 17 Rev 1/2001

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Mary - State Registrar		tificate of D		Re	g. No 2007	37155
	Physicia		Decedent's Name (First, Middle, Last) BILLIE MAE MCLENDON				2. Date of Death Month NOVEMB	ER 14 20	3. Time of Death
	/Medic Examin	200	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L		110 12-1-	4c. County of Deat	
	Funeral		Calvert Manor Health Ca. 5. Social Security Number 6. Sex 7. Age (In	re yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth	Cecil 9. Bird	hplace (State or Foreign
	Director		525-26-6209 1□M 2MF 8	35 Yrs.	Months Days	Hours Min.	Aug 12	1922 Te	exas
	ryland rhow		10a. State 10b. County 10c	c. City, Town or Loc Earlevi					10d. Inside City Limits 1 ☐ Yes 2X No
	the Ma 28a-f s notified	recto	MD Cecil 10e. Street and Number	Earlevi	10f. Zip Code	-	10	g. Citizen of What Co	
	23a or ust be	ral Di	35 Peddlers Lane		21919			U.S.A.	siana Indian
920	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	/es 2⊠ No s, Give 1 or Dates:		panic Origin? (Sp., Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
15-0	n 72 ho "natur edical	leted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give . life. [16a. Decedent's Usual Occupation (Give kind of work done during most of worki life. DO NOT use retired)		16b. Kind of Business		/Industry
212	d 2 should be filed th and Mental Hygi 7 is marked other traumatic event, t	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Но	omemaker		- /Final Bildella B	Own Home	<u> </u>
and		To Be	17. Father's Name (First, Middle, Last) Mumford M. Ainsworth			18. Mother's Name Ollie	Fae Fox	,	
, Maryland 21215-0036		-	19a. Informant's Name/Relationship (Type. Print) Leila Craig (daughter)	P.O.	Box 168	8 Earl	eville	City or Town, State, MD • 219	19
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once,		1 ☐ Burial 2 ☑ Cremation 3 ☐ Hemoval from State 4 ☐ Donation 5 ☐ Other (Specify)	Kent Cr		11/2	20/07	Smyrna,	DE.
Bal	permit Depar Impor any in once,		21. Same of Fundal Service Licens	0510 G	alena Fu 18 West	neral E Cross S	Home of St. Gal	Stephen ena, MD.	L. Schaech 21635
	Physician /Medical Examiner	er	Due to (or as to	onsequence of):	er the mode of dying	, such as cardiac ~ctiow	or respiratory arre	st,	Approximate Interval Between Onset and Death
68760, 3	ificate be executed g physician and as the burial-transit	ledical Examin	Sequentially list conditions, if a y learn 1 and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a condition of the condition o	onsequence of):					
O. Box (ath cert	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>			23d. Date of de Month	elivery Day Year
Δ.	quires that the de n signed by the a uld be detached t	by	Part II. Other significant conditions contributing to death but no Dementia of Alzheir			n in Part I.	23e. Did tol		to the cause of death? Probably 4 □Unknown
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	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatient	2 ☐ ER/Outpatier	nt 3 DOA Othe	** •	th <i>(Check only on</i> ome 5 ☐ Reside	e) ence 6 □Other (Sp	ecify)
n or		on: T	27. Manner of Death 1 Natural 5 ☐ Pending (Month, Day Yo	ear) 28b. Time o	Work	?	28d. Describe ho	ow injury occurred	
Division	Atten r death ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury building, etc. (3			1 ☐ Yes 2 ☐ No tory, office 28f. Location (Street and Number or Rural Ro City or Town, State)		Rural Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of n 2 Medical Examiner: On the basis of examiner and manner stated	amination and/or in	th occurred at the tim	ne, date and place pinion, death occu	, and due to the or rred at the time, or	ause(s) and manner a late and place, and du	as stated. ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License		2	9d. Date signed (Mor	nth, Day, Year)
	^		30. Name and address of person who completed cause of death	h (Item 23a) (Type,	Print)	58354		11/10/11	<u>∨</u> →
100	J		DEIL E. LATTIN, M.D 1	Signature	Print) ONIAL W	Day, R	ising	oun, MO	21911
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) St. Registrar's NOV 2 0 2007	J. J.	W.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Elizabeth Margaret Mettam October 0 2007 07:50 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death South River Health & Rehab. Center Anne Arundel Edgewater If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/19/1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 T F 212-03-0895 92 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21037 2720 Solomons Island Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1□Yes 2No Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) William Townsend Lee Mary Rhode 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Lee Purdy/Daughter <u> 2726 Solomons Island Road, Edgewater, Maryland 21037</u> 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory 10/31/2007 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): hulti wo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform

Physician /Medical Examiner Examiner be executed

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

/Medical

10a. State

Director

Funeral

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Completed

Be

attending physician for use as the buria ed by the a ate has been signed by page 2 should be detack To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director After this certifica completely filled in by the funeral director, p

Physician/Medical

Completed

Be

ဥ

Certification:

Medical

Division or Vital Records, P.O. Box 68760

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

6 ☐ Could not be

determined

25. Was case referred to medical examiner?

1 Yes 2 No

5 Pending investigation

Hospital:

28a. Date of Injury (Month, Day Year)

Chawan, MD

1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 M Nursing Home 5 Hesidence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier

27. Manner of Death

2 Accident

3 ☐ Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

10062534

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar 31. Date filed (Month, Day, Year)
NOV 0 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DITA NEWLAN. MIN 1441 WASHINGTON RIS, EXCEWNIER MD 32 Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			State of Maryland / De	partment of Health and Mer	-	
			, FOI	ertificate of Death	Reg. 1	
r.	BN II		Decedent's Name (First, Middle, Last)		Date of Death	3. Time of Death
	Physicia /Medic		EUNICE MORTON		10 3	2007 10.00 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	Fundad	-	South River Health & Rehab. Center 5. Social Security Number	Edgewater ay) If Under 1 Year If Under 24 Hrs. 8.	Date of Birth	Anne Arundel 9. Birthplace (State or Foreign
	Funeral Director		234-20-7736 1 M 2 T F 87 Yrs	Months Days Hours Min.	Date of Birth (Month, Day, Yes 3/7/1920	West Virginia
*	pu v		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	Location		10d. Inside City Limits
	Maryla f shov ied at	ō		ewater		1 Tyes 2 No
	r 28a-	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	th with use 23a oust be		87 Stewart Drive, Apt. 432	21037		USA
	er dea items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.
350	irs aft	by F	1 ☐ Never Married 2 🖾 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	1 ☐ Yes 2 🛣 No Specify:		Specify: White
215-0036	72 hou natura lical E	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation	16b	. Kind of Business/Industry
2	vithin 7 ne. han "i e Med	mple	Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of working e. DO NOT use retired) Florist		Floral
Z	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. dother than "natural", or items 23a or 28a-f show do other than "matural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Ç	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fi	irst. Middle. Maid	
	e d d	To Be	Edgar Wiseman	,	Bucklan	<i>'</i>
Mary	ges 1 and 2 should be nt of Health and Menta If item 27 is marked or or other traumatic ev	_	19a. Informant's Name/Relationship (Type. Print) 19b. M	ailing Address (Street and Number or Rural Ro	oute Number, Cit	ty or Town, State, Zip Code)
_	and 2 lealth m 27 i			Stewart Dr., Apt. 43		
saitimore,	Pages 1 and the sunt of Hest int: If item inty or other			sposition (Name of Date crematory or other place) Crematory 11-1-0		Location - City or Town, State lgewater, MD
	permit. Pag Department Important: I any Injury o		4 Donation 5 Other (Specify) 21. Signature Of Meral Service Licensee	22. Name and Address of Facility Geor		
n	Dep Imp any onc		* Mille	2973 Solomons Island		
П	<u>.</u>		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Lenal Failure)	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	Lenal Failure Artery dise	2	
Ş	.	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	- Anoug ause	ase	
	te be executed ysician and ne burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	<u> </u>		
/6 <u>0</u> ,	oe exe cian al nurial-1		resulting in death) Last Due to (or as a consequence of):			
200	certificate be executed rding physician and ise as the burial-transit	dical	d			
ROX	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	- T		23d. Date of delivery
	death	sicia	in the past 12 months? 1 \(\times \) 2 \(\times \) No 1 \(\times \) 1 \(\times \) 2 \(\times \) No	3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
7. O	at the	Phys	Part II. Other significant conditions contributing to death but not resulting in the	o underlying source given in Bort I	22a Did tahaas	to use contribute to the cause of death?
as,	requires that the een signed by th nould be detache	by	Dia Bell, Hunes tending in the	v. Pancytopenia.	1 ☐ Yes	2 □ No 3 □ Probably 4 Unknown
	w requ	letec	Taxin hocotoponia	, restruct	24a. Was an	24b. Were autopsy findings available
Ĕ	siclan; The law certificate has b rector, page 2 sl	Completed	- Work is as we serve		autopsy performed	prior to completion of cause of
		Be C	25. Was case referred to medical examiner?	26. Place of Death (C		10 10165 2010
0 0	ding Physiclan; 1. After this certific funeral director,	To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa			e 6 □Other (Specify)
ם	ding Phys n. After this funeral di	ion:	27. Manner of Death 28a. Date of Injury 28b. Tim Inju 29b. Tim 29b. Tim Inju 29b. Tim 20b. Tim 20b. T		. Describe how in	njury occurred
UIVISION	Attending Physiclan; r death. ector: After this certifica by the funeral director,	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm		Location (Street	and Number or Rural Route Number,
5	tal or s after al Dire ed in t	Certi	4 Homicide determined building, etc. (Specify)		City or Town, Si	ate)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only) 1 ★ Certifying Physician: To the best of my knowledge, of 2 ★ Medical Examiner: On the basis of examination and/of			
	o the ithin 2 o the omplei	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	F ≯ F ŏ		Prita Dhawan, MD	D0062530	Α .	11/1/2007
;	0.1		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	!	
0	A.H.		RITA DHAWAN, MD 144 W	ASHINGTON RI	, boc	TE WATER, MD
0	Sta Registr	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 .		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11/1/2007 Physician Samuel Miller 11:00pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regency Park Gambrills Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min **1** ★ M 2 □ F 216-24-8675 79 Director 8/29/1928 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at MD Anne Arundel Odenton 1 ☐ Yes 2x No notified Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ortant: If Item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be I 707 Harvest Run Drive 21113 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married MYes 2□ If Yes, Give Year or Dates: ²□No Korea Baltimore, Maryland 21215-0036 1 Yes 2000 Specify. White þ Specify: 3€Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stationary Engineer USNA ulth and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel J. Miller Louise Curley ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Jay Miller Son 707 Harvest Run Dr. Odenton, MD 21113 permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State xxx Burial 2 ☐ Cremation 3 ☐ Removal from State 11/6/2007 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery Glen Burnie, MD 21. Signature of Funeral Service Live 22. Name and Address of FacilityHardesty Funeral Home, P.A. 70 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician M 04 al /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any leading to immediate Due to for as a consequence of if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed Exami and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9 I Inknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 TYes 2 ☐NO 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Ho 24a. Was an certificate has 1 2 Yes Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) (111,5/2) Be Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient P 3□ DOA 6 Dether (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director: After t After Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

the

2

State

Registrar

DHMH 17 Rev 1/2001

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

orhai

led (Month, Day, Year)

NOV 0 2 2007

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

			For State	State of M	ıaryıan	•	artment of F rtificate of	ieaith and ivi <i>Death</i>	,	0		
ß	5) ,		Registrar 1. Decedent's Name (First, Middle, L	ast)		001	tinoato or	Douth	2. Date of De	Reg. No.	17	3 Sime of Death
	Physici		David Everett N	lash. Ir					Month	er 4, 200	ear 7	00:22 AM
	/Medio		4a. Facility Name (If not institution, ga)		4b. City, Town, o	r Location of Death	NOVCILID	4c. County of		00.22 AT
			Union Hospital o	of Cecil Co	ounty		Elktor	n		Cecil	L	
\(\frac{1}{2}\)	Funeral		Social Security Number 6.	Sex 7. A	ge (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birthpla Countr	ice (State or Foreign y)
, s	Director		245-46-5342 Usual Residence of Decedent	XXVIII Z LLLI	75	Yrs.			May 19			Carolina
	land ow tt		10a. State 10b. County		10c. City	/, Town or Lo	cation				100	d. Inside City Limits
	Mary -f sh	Ď	Maryland Ced	i1		E1kto	n			1 ∐Yes 2 X No		
	h the or 28a s noti	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Countr	y?
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Medical Examiner must be notified at		1 Malvern Drive	<u> </u>			2192	1		United S	nited States	
	r dea tems er mu	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - Black.	American White, et	
36	s afte ; or if	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give	No		1 ☐ Yes 2√€ No		,	Specify:		
2-0036	hour tural' al Ex	q pe	15. Decedent's E	Year or Dates:		16a Decer	lent's Usual Occup	nation		16b. Kind of Busi		
5	in 72 n "na Nedic	olet	(Specify only highest g	rade completed)	- \	(Give	kind of work done DO NOT use retired	during most of worki d)	ng	TOD. KING OF BUSI	ness/mag	istry
212	with giene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)			nt Operato		Constr	ucti	on
ğ	be filed ttal Hygi d other event, th	BeC	17. Father's Name (First, Middle, Las	et)				18. Mother's Name	(First, Middle	, Maiden Surname))	
<u>a</u>	uld by Menta arked atic e	일	David E. Mash, Sr. Nellie Miller									
Maryland 2121	2 should and Mer is marke aumatic		19a. Informant's Name/Relationship				-	and Number or Rura			tate, Zip C	Code)
	1 and Health em 27		Helen L. Mash /	Spouse				ive, E1kto			.921	
Baltimore,			20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3	☐Removal from State	20b. P	face of Dispo emetery, crer	sition (Name of natory or other plac	ce) Noven	iber	20c. Location - C	ity or Tow	n, State
Ħ	permit. Pages Department of Important: If II any injury or o		4 Donation 5 Dother (Spec	1	No:	rth Ea	st Method	dist 7, 20	07	North Eas		aryland
Ba	Depar Impol any ir		21. Signature Fureral Solvice do	AS A S				ss of Facility Cro				1 101001
			23å Part1 Enter the disease or con	mnlications that cause	d the death						_	y1and21901 Approximate
20	M. Th. Time		23a. Part1. Enter the disease, or con shock, or heart failure. List onl Immediate Cause (Final	y one cause on each I	line.						(Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a. Due to (or as	15 0		ncemo	me a	nd ile	spiralo	m	9 elems.
	Examiner			Due to (or as	s a consequ	elice oi).						,
		Jer	b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):									
T	cuted nd ransit	Examiner	that initiated events	C.								
oʻ	an ar irial-tı		resulting in death) Last	Due to (or as	s a consequ	uence of):						
68760,	tificate be executed g physician and as the burial-transit	edical		d								
-			IF FEMALE:							1		
ROX	leath certifi attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	death 3	Ectopic pregnanc	у		23d. Date Mont		/ Day Year
	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnanta 9∏Unknown	at time of d	eath 5∟	Other (specify) _					
1	The law requires that the death oer atendir ate has been signed by the attendir bage 2 should be detached for use	Ph	Part II. Other significant conditions	contributing to death I	but not resu	ılting in the ur	nderlying cause giv	ren in Part I.	23e. Did t	obacco use contrib	ute to the	cause of death?
Records,	uires 1 sign 1d be	Completed by	Copo cr	G GF	11-	2,	ESRD	GNHD	. 10	Yes 2□ No 3	Proba	bly 4 □Unknown
S	w req	lete	DVD DI	/ERTIC	1 +1 10		ANG	EMIN	24a. Was	an 24b We	ere autops	sy findings available
	rsician; The law s certificate has t lirector, page 2 s	Ĕ				712	000	3 -	auto perfo	psy pri prmed? de	or to comp ath?	pletion of cause of
Vital			25. Was case referred to medical	LOPATE	и.У	CVY+	1-17-	26. Place of Death	1 Yes		∃Yes 2	! ∐ No
	ysici is cer direct	To Be	examiner? 1 ☐ Yes 2 No	Hospital:	ient 2 🗌	ER/Outpatien	t 3 DOA Oth	or:		dence 6 □Other	(Specify)	
ō	ding Ph h. After thi funeral		27. Manner of Death	28a. Date of Inj (Month, Da		28b. Time of Injury	28c. Injur Wor			how injury occurred		
<u> </u>	endir ath. or: Af he fur	atio	1 Natural 5 Pending investigation	on	, , , , ,	,,		Yes 2 □ No				
Division or	il or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not determined	200. Flace of III	jury - At ho tc. <i>(Specif</i> y	me, farm, str	eet, factory, office	2	28f. Location (City or To	Street and Number wn, State)	or Rural	Route Number,
	oital o urs aff eral D							<u> </u>				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the funeral director, with the funeral director, completely filled in by the funeral director,	Medical		hysician: To the best	of examina							
	o the ithin 2 o the o the o the o the o	Med	29b. Signature and title of certifier	and manner s	iateu.		29c. Licens	e number		29d. Date signed	(Month. D	ay, Year)
1	F≯Fŏ		1/1	J .				00 6373	70	11/4/0		
•			30. Name and address of person who	completed cause of	death (Item	23a) (Type.				,,, 110		
	5		NAMITA TO	1 - 11 0		1.25.3	~ .	FILL TO	3 ~~			

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV

6 2007

32. Ragistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / Dep Amend Item 1 per dr., g874G1	2/03/97#	b eath	rılaı ⊓ygı Re	2007	37160
零	Diversited	e j	1. Decedent's Name (First, Middle, Last)		2	. Date of Deatl Month		3. Time of Death
Ы	Physici /Medic		Manijeh Massumi Manijeh Shambayati	Massumi	N	lovember		3:30 p M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County of Death	
		2.	Suburban Hospital	Bethesda			Montgomery	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 M 2 🖾 F Yrs.	Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign ntry)
	Director		215-98-4464 70 Usual Residence of Decedent		<u> </u>	íay 2, 19	37 Ira	n
	land ow It		10a. State 10b. County 10c. City, Town or L	ocation				10d. Inside City Limits
	Mary f sh	호	MD Mantagara					1 □Yes 2√√No
	r 28a	Director	MD Montgomery Bethesda 10e. Street and Number	10f. Zip Code		10	Og. Citizen of What Cou	ntry?
	h with		6774 Surreywood Lane	20817			USA	
	deat	Funeral		Was Decedent of H	lispanic Origin? (Specif an, Mexican, Puerto Ri	fy Yes or No-	14. Race - Americ	
9	after or Ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 No		oan, etc.)	Black, White,	etc.
15-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:				Wh:	ite
2	72 h "natu	Completed	(Specify only highest grade completed) (Give	edent's Usual Occup e kind of work done	during most of working	. ₽	16b. Kind of Business/In	dustry
712	vithir ene. than	E	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired	1)		Destruction	
2	Hygie Hygie Int, th		12 Homema 17. Father's Name (First, Middle, Last)	ker	18. Mother's Name (F		Private	
Maryland	be ad part all and a seven	Be C			Ezat Vakili			
2	2 should be and Menta Is marked aumatic ev	ဥ	Choulam-Hossian Shambayati 19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street			City or Town, State, Zij	n Cade)
<u>8</u>	nd 2 s Ith ar 27 Is 1 trau				Moraga, CA 94		ony or romi, otato, za	0000)
စ်	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		20a. Method of Disposition 20b. Place of Disp	osition (Name of	Dat		20c. Location - City or To	own, State
Baltimore,	0 0 ± 5		1 M Bunal 2 Oremation 3 Hemoval from State	matory or other plac	177/01/0	1007	and the MD	
	permit. Pag Department Important: any Injury o			emorial Parl 2. Name and Addre	ss of Facility	-Dinaldi	ockville, MD Funeral Home	Tno
ñ	Der Preparent		An Vall & Miller He 1	1800 New Hai	mpshire Avenu	e, Silve	r Spring, MD	20904
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or hear failure. List only one cause on each line.	ter the mode of dyir	ng, such as cardiac or r	respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final					Onset and Death 5 days
	/Medical		disease or condition resulting in death) a. intercranial hemorrha Due to (or as a consequence of):	K-E				J days
1	Examiner		Sequentially liet conditions					
	₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Energy of any ing Cause (Disease or injury					
2	ecute and trans	Examiner	that initiated events c.					
Ď,	be ex cian a		Due to (or as a consequence of):					
68/60,	lificate be executed g physician and as the burial-transit	edical	d		···			
	± 00 €		IF FEMALE: 23c. If yes, outcome pf pregnancy				22d Date of deliv	
X Q Q	the death certifi y the attending I ched for use as	cian	in the past 12 months?	□Ectopic pregnancy □ Other (specify)	/		23d. Date of deliv Month	Day Year
j.	the c y the ched	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	(
 T	requires that een signed by nould be deta		Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute to t	the cause of death?
cords,	quires n sign	d by				1 ☐ Ye	es 2 No 3 Pro	bably 4 K∏Unknown
ဝ္ပ	lav re as tee 2 sho	Completed				24a. Was ar	24b. Were auto	opsy findings available
r	The law te has a age 2 s	Шо				autops perforn 1 Yes 2	y prior to co ned? death? ☆☐No 1☐Yes	ompletion of cause of
NIT S	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical		26. Place of Death (6		24	2010
_	S S S	10 E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Oth	er: 4□ Nursing Home	e 5 ☐ Reside	nce 6 □Other (Speci	fy)
0	ding Ph h. After thi funeral		27. Manner of Death 1 X Natural 5 □ Pending (Month, Day Year) 28b. Time (Month, Day Year) Injury	of 28c. Injur Wor	y at 286 k?	d. Describe ho	w injury occurred	
IVISION	tendi eath. tor: A the fu	cati	2 Accident investigation		Yes 2 □ No			
<u> </u>	al or Attending F after death. I Director: After d in by the funera	Certification:	3 Suicide 6 Gould flot be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	281	f. Location (Str City or Town	reet and Number or Run , State)	al Route Number,
-	pital ours a eral I		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the tir	me date and place an	d due to the ca	ause(s) and manner as	stated
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in one)	nvestigation, in my o	ppinion, death occurred	at the time, da	ate and place, and due t	to the cause(s)
	To th To th comp	Me	29b. Signature and title of Contifier	29c. Licens	e number	29	9d. Date signed (Month,	Day, Year)
	J.		I show show	1060	304		11/2/07	,
	7		30. Name and address of person who completed cause of death (Item 23a) (Type		1		, , - , 0 /	
			Dr. Sujoy Tagore, 8600 Old Georgetown Road	, Bethesda,	MD 20814			
	Sta		31. Date filed (Month, Day, Year) 32. Figistrar's Signature	heals !				
	Registr	aı	LEGIE OF COOL PORTING TO 16	The state of the s				

MASSUMI, MANITEH 9-2-07 1530

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MCMANNIS 9:55 P. M MARY DOROTHY 2007 NOVEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GARRETT COUNTY MEMORIAL HOSPITAL OAKT, AND GARRETT 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🔀 F 83 219-76-4805 31,1924 MARYLAND Director JAN. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 XNo LAVALE MD ALLEGANY Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 924 WEIRES AVENUE 21502 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: þ WHITE 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be marked ROBERT LOUIS KEMP EMMA BLANCHE BRIDGES 2 and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at Important: If item 27 is any injury or other trau WILLIAM H. DAWSON / SON 1900 MUDDY CREEK ROAD, ANDRIDGE, TN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐Removal from State MT. ZION METH.Ch.CEM. 11/05/2007 4 ☐ Donation 5 ☐ Other (Specify) KEYSER, WV 21. Signature of Funeral Service Livense Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A.
202 GREENE STREET, CUMBERLAND, MD Unno noches 21502 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 10 days disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iriginy that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical as the l use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy lo. Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2XNo detached a∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe chronic obstructive pulmonary disease 1 TYes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? diabetes mellitus type two 24a. Was an page 2 autopsy performed? Yes 24 No 1 Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 1 Dnpatient 2 ER/Outpatient 3□ DOA Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 (Month, Day Year) Hospitai or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No safter death. 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C [Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0025759 NOVEMBER 1,2007 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter K. Naumann, M.D., P.O. Box 247, Accident, MD MLS 21520

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 9 2007

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Registrar's Signature

To street and Number 100. Zip Code 20685 United States				1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.?	37162										
Solomons Nursing Center Solomons Nursing C	i i	Physicia	an		3. Time of Death										
Solomons Nursing Center Director Direct				4 Ch Tanada - 1	4:20 P.M.										
STORY Control Contro	F	Examin	lei												
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18		r 28a-	irect	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country	10g. Citizen of What Country?										
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Physician Medical Examiner Ph	Mai	nd 2 sh ith and 27 is n			· ·										
Physician Medical Examiner Ph	ore,	ges 1 ar t of Hea if item or other		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Tow	wn, State										
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FFEMALE 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 4	3760	ate be nysicia he bur	ical	S											
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Signature and dilted grants and manner as stated. State	.O. Bo	the death or y the attend	nysician	23b. Was decedent pregnant in the past 12 months? 1 2 Fetal death 3 Ectopic pregnancy 23d. Date of deliver 1 1 1 1 1 1 1 1 1	•										
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN C SURANA 5851 - Deale Church ton Road Deale m'D 2075 State 31. Date filed (Month, Day, Year) 1 32. Registrar's Signature	/ita	clan: ertifica ector, p		25. Was case referred to medical examiner?											
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	i	5/08		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN C SURANA 5851- Deale Churchton Donal Doale mit	2075										
				23. Registrar's Signature											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death October **Physician** Walter L. Oliver 2007 09:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number Sex 14EM 2□F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year, 10/29/1932 9. Birthplace (State or Foreign Country)
New York **Funeral** Months Days Hours Min. 218-28-5759 75 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 □ Yes 2 No Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 924 Boom Wav 21401 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1951–55 Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Oil & Gasoline 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonard A. Oliver Catherine M. Paisley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joycelyn M. Oliver/Spouse 924 Boom Way, Annapolis, Maryland 21401 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 11/05/2007 Crownsville, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Lenses 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Interstitia 1mast4 disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 100 ို 1 XInpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1/ Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

Examiner that the death certificate be executed and burial-trar Division or Vital Records, P.O. Box 68760 attending physician for use as the buria ģ signed t peen page 2 s certificate the Hospital or Attending Physician: this certific al director,

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

72

12 should be filed whand Mental Hygier Is marked other the

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any Injury or other traumatic ew

6 Could not be determined 3 Suicide 4 ☐ Homicide

29a. Certifier

(Check only one)

29b. Signature and title of certifie

Klera

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

trinopdis Mel

-MD

and manner stated.

29c. License number D24804

VECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peterson

31. Date filed (Month, Day, Year) NOV 0 1 2007

. Registrar's Signature

MD

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Carl Patrick Osgood 30, 2007 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8220 Sam Hill Drive Owings Calvert County If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**∑**M 2□F Yrs 214-60-2763 Director 53 Jan. 29, 1954 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location a or 28a-f show t be notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Calvert County Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a Examiner must b 8220 Sam Hill Drive 20736 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after of tealth and Mental Hygiene.

77 Is marked other than "natural", or Ite 1 □ Yes 2 📉 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Vice President of Construction Construction Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Goudy Osgood Margaret Slattery မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana A. Osgood 8220 Sam Hill Drive, Owings, (Wife) Maryland 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov. 5, 1 XBurial 2 □ Cremation 3 □ Removal from State Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 2007 21. Signature of Funer 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part . Enter the disease, . Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes ate has been signed by the page 2 should be detached 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2B No 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 25 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation To the Hospital or Attending 1 Natural 2 Accident Injury 1 ∏ Yes 2 ∏ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan D.

Lowenthal M.D. 110 rus

D3317

110 Hospital Drive, Prince Frederick, MD 20678

October 31, 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** 2007 Gertrude E. Pearson Oct. 5:52 AM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner 5906 Central Avenue Heights Prince Georges If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (Stete or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 □ xF 83 Yrs Director 578-20-1748 04-11-1924 Wash. Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic avent, the Medical Examinar must be motified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 □ No Director MD Prince Georges Capitol Heights 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 5906 Central 20743 Funerai Avenue USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Manital Status 1 ☐ Never Married 2 ☐ Married ☐ Yes 2♥ No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Records Clerk 12 Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be Leroy Richardson Etheline Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7909 E. Nalley Road Landover, Maryland 20785 19a. Informant's Name/Relationship (Type, Print) Phyllis Brown (Daughter) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 15€ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial 11-06-07 Suitland, MD 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility
Ralph Williams Funeral Service 1813 Potomac Ave., SE; Wash., DC 20003 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical chronic rena Examiner Due to (or as a consequence of) Examiner multiple myel been signed by the attanding physician and should be datached for use as the burial-transit or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I 1 Yes 2 No 3 Probably 4 Unknown None 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? Completed 24a. Was en autopsy performed? certificate has 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Be 25. Wes cesa referred to medical examiner? 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home ဥ 1 Yes 2 No 5 Residence 6 □Other (Specify) this eral Director: After the filled in by the funeral 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No daath. 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier complataly (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) Suite 430 Peter Schissler, 7500 Greenway Center Drive, MD Greenbelt, MD 20770 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State NOV 0 5 2007 Registrar

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31. Date filed (Month, Day, Year)

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Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 3 Prot 1 Ve	amil	
autopsy performed? 1 Yes 2 No 1 Yes 2 N		
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autopsy performed? 1 Yes 2 No 1 Yes 2 N	v requ	ppsy findings available
25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 28. Date of Injury (Month, Day Year) 1 Yes 2 No 28. Date of Injury M 1 Yes 2 No 28. Place of injury at Work? 1 Yes 2 No 28. Place of injury at Work? 1 Yes 2 No 28. Lingury M 1 Yes 2 No 28. Location (Street and Number or Rura City or Town, State) 29. Certifier 29. Certifier (Check only one) 29. Certifier (Check only one) 20. Date of Injury M 1 Yes 2 No 28. Place of injury at Work? 1 Yes 2 No 28. Place of injury at Normal Accident Normal	he lave has age 2	mpletion of cause of 2□ No
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A FECAL POWE (T N	· · · · · · · · · · · · · · · · · · ·
30. Name and address of ggrson who completed cause of death (Item 23a)/Type, Print)	\	
RW 12 Spend Mill, PD 2001 Medical Parkway chinapolis, 10	12	
State Registrar 31. Date filed (Month, Day, Year) NOV 0 6 2 007	State Registrar	

State

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Powers Eugene November 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 10711 Mexico Farms Road, SE Cumberland If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 220-32-2706 Director 70 04/07/1937 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🗖 No Allegany Cumberland Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 10711 Mexico Farms Road, SE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 X Yes 2 No 1955—
If Yes, Give
Year or Dates: 1959 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify. <u>ک</u> 3 ☐ Widowed 4 🔀 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Tire and Rubber <u>Manager</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Leo Powers Mary Alfreda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 327 South Mason Street, Harrisonburg, VA 22801 Vicki M. Puckett / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cem. @ Rocky Gap 11/9/2007 Flintstone, MD MD Vet. 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service License 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Carcinoma Small cell luna 1 year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown prostate Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Adenocarcyona of colon pertormed' 3) Laryna ecl Carcheme
25. Was case referred to medical examiner? 2 1No 2 No 1 ☐ Yes 1☐ Yes 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 💢 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0059987 November 7, 2007 5+ nom 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nas 902 Seton Drive, Cumberland, MD Christopher Vagnoni, M.D., 21502 31. Date filed (Month, Day, Year) NOV 0 8 2007 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** NOUZMBER **JOHN** J. PAPA 05 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Misbury CEMICA Keninsula ional 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1**∑** M 2□ F Maryland 214-60-8871 47 April 11, Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "naturai", or items 23a or 28a-f shovedical Examiner must be notified at Maryland Somerset Crisfield 1 ☐ Yes 2 ☑ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3667 Country Club Road 21817 U.S.A. Completed by Funeral Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Amed Folces: 1 Yes 2 No If Yes, Give Year or Dates: 1. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√€ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Waterman Seafood 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John J. Papa Dorothy Margaret Loughlin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William S. Papa (Brother) 116 Hall Highway - Crisfield, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/9/07 Paul's Cemetery Marion Station, MD 21. Signature Pungal Service Lightee 22. Name and Address of Facility H Bradshaw & Sons Funeral Home Robert Bradshaw Ir 306 W. Main St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPOXEMIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UNG METASTAMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed Exam that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 🛂 No been signed by the should be detached 9 Completed Be 2 Certification:

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: filled in by within 2

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Part II. Other signi	ficant conditions o	ontributing to death but not res	sulting in the underlying	ng caus	e given in Part I.	23e	. Did tobacco u 1 Yes 2	use contribute to the cause of death?			
							. Was an autopsy performed? Yes 2 ∕□No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
25. Was case refer		26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2☐	11 0	Hospital: 1 Impatient 2	Residence	6 □Other (Specify)							
27. Manner of Death → Natural 5 □ Pending 2 □ Accident investigation			28b. Time of Injury	28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Des	d. Describe how injury occurred				
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At h building, etc. (Speci		28f. Loca City	8f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one)		ysiclan: To the best of my kni nlner: On the basis of examinated and manner stated.) and manner as stated. d place, and due to the cause(s)			
29b. Signature and title of certifier				29c. License number 29			29d. Dat	29d. Date signed (Month, Day, Year)			

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SHORE DR., SALISBURY,

MD

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NOV 0 8 Registrar

DGESH

31. Date filed (Month, Day, Year)



614 EASTERN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

07-08353 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007

NIC OTTIC	1- For State Certificate		Reg. No.
Physician/	Registrar	2. Date	e of Death 3. Time of Death
/ledical Examine		Mor Oct	ober 27, 2007 Year 0928 hrs
}	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	5922 Martin Luther King Jr Avenue	Seat Pleasant	Prince George's
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Dave Hours Min	9. Birthplace (State or Foreignwash., D.C.
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Maryland 28a-f show datonce. ector	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
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hours after "natural", Examiner	or Dates:	edent's Usual Occupation (Give kind of work do	ne 16b. Kind of Business/Industry
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altii.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility H.S. Washington &	Sons Co., Inc. N.E., Washington, D.C. 20019
o 50 11	Many W. Shall	4925 Burroughs Ave.,	N.E. Washington, D.C. 20019
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BO) e death the att	1 Yes 2 No 9 Unknown		
P.O. B	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
S, P.C			24a. Was an 24b. Were autopsy findings available
Records, I The law requires freate has been sig , page 2 should be			autopsy performed?
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Vital Rec ysician: The his certificate director, page	25. Was case referred to medical	26.Place of Death (Check only of tient 3 DOA Other Nursing Homes	
F Vid	o 1 ✓ Yes 2 No 1 Inpatient 2 ER/Outpa		ne 5 Residence 6 Other: Scene Describe how injury occurred
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Sior Attend r death ector: by the	Oct 27, 2007 0920 hr Investigation 28e. Place of Injury - At home, farm,	s	ccation (Street and Number or Rural Route Number, City
Division of Vital Records, ospital or Attending Physician: The law require hours after death. Interal Director: After this certificate has been siy filled in by the funeral director, page 2 should be Completed.	3 Suicide 6 Could not be determined (Specify) Convenience Store		or Town, State) Martin Luther King Jr Ave, Seat Pleasant, MD
hou be little		occurred at the time, date and place, and due to	o the cause(s) and manner as stated.
vithin 2 To the complet	(Check only 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or inveand manner stated. 29b. Signature and title of certifier	stigation, in my opinion, death occurred at the t	ime, date and place, and due to the cause(s)
To To con		29c. License number	29d. Date signed (Month, Day, Year)
	Dome nu incorti, M.D.	O.C.M.E.	October 28, 2007
Q.	30. Name and address of person who completed cause of death (Item 23a)	111 Penn Street, Baltimore, MD 21	201
	Donna M. Vincenti, MD Assistant Medical Examiner te 31. Date filed (Month, Day Year) ar NOV 0 5 200 32. Registrar's Sir hature	TIT FEIII JUEEL, DAILIIIUTE, IVID 21	201

			1 - For State Registrar	State of Mar	•	artment e <i>rtificate</i>				Re	g. 12 0 0	7	37172
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Las	street and number)	sell	4b. City, T	Fown, or	Location of		2. Date of Death Month CHO DER	Day 30 20 4c. County	Year O 7 of Death	3. Time of Death
8 . K	Funeral Director		5. Social Security Number 6. Sec. 212–46–0300 11	X Age	in yrs. last birthda 99 Yrs.	y) If Under 1	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 8/14/1	Year) 908	Cou	place (State or Foreign intry) aryland
	he Maryland 28a-f ehow culfied at	ector	10a. State 10b. County MD	1	Oc. City, Town or Balt	Location imore	Cada			10	og. Citizen of W	/hat Cou	10d. Inside City Limits 1 Yes 2 No
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23e or 28e-1 ehow the Madicel Exame or Liust be mulled at	ted by Funeral Director	3320 Benson Ave. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: cation a completed) 16a. De a completed)			Specify:	, Puerto F	cify Yes or No- lican, etc.)	USA 14. Race	e - Amer k, White	ican Indian, , etc. hite
and 21215	be filed within 7 ntal Hygiene. ed other than "n	Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life	re kind of work DO NOT use Home	e retired,) 2 r 18. Mother	r's Name	(First, Middle, N			
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!, or iteme 23a or 28a-1 show enty injury or other traumatic event, the Mudical Erami mermusits inclined at once.	То	Bernard T. Murphy 19a. Informant's Name/Relationship (7 Richard Russell 20a. Method of Disposition DBurial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Pungfal Service Licen	Son Removal from State	808 20b. Place of Discemetery, cr New Cath	Miner position (Namematory or other edral 22. Name and	Rd.	Crow	nsvi: Da 11/3,	_	City or Town, 21032 Coc. Location - Baltimoneral H	City or T	own, State
,092	Physician /Medical Examiner	ical Examiner	23a. Part1. Enter the disease, or companies, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	heim & consequence of):	nter the mode	o of dying	ells	cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death V-eurs
.O. Box 68	death certific e attending pl od for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	□Ectopic pre					23d. Date Mor		very Day Year
Q	v requires been sign should be	Completed by Ph	Part II. Other significant conditions of Chromic M	entributing to death but of the second of th	not resulting in the	underlying ca	ause give	en in Part 1.		1 ☐ Ye	s 2 No	3 Pro	opsy findings available
Division of Vital Records,	sician: The certificate h rector, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ₩No	Hospital: 1 ☐ Inpatient	2 ER/Outpati	ent 3 DO	A Othe	r M		autops perform 1 Yes 2 (Check only one) 1 Reside	No 1	leath?	ompletion of cause of 2 □ No
vision o	ding h. After fune	ertification: T	27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide 27. Manner of Death 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Y	· At home, farm,	М		rat (? Yes 2 □ N	No	8d. Describe ho 8f. Location (Str. City or Town	reet and Numbe		ral Route Number,
۵	To the Hospital or Attenwihin 24 hours after death To the Funeral Director: completely filled in by the	edical Ceri	29a. Certifier 1X Certifying Ph					2.00000000	use(s) and ma				
)	To the i	Me	29b. Signature and title of certifier 30, Name and address of person who of	ample and cause of doa	12-17 th (item 23a) (Tun			number	1		od. Date signed C+obe		21227
	Sta Regist		Ming (Month, Day, Year)	3320 Ben	SM Au s Signature	berli		Bal	tim	ore, l	Nouryl o	mod	71227

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Christine Anne Rice 2007 6:30 a M October 31 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery General Hospital 01ney If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1 M 2 X F 550-66-0945 65 November 27,1941 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 ☑ No Maryland Montgomery Director Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or Items 23a or the Medical Examiner must be IISA 20906 3116 Farnborough Court Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Î No Specify Specify: White Completed by 3 Widowed 4 Noivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) rages 1 and 2 should be fill out of Health and Mental Hit; If Item 27 Is marked oth y or other traumatic eventy Be Mary Kendall Edgar Rice ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3417 Miars Farm Circle, Chesapeake, VA - daughter Mrs. Kim Topping 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or 11/7/2007 Brentwood, MD Fort Lincoln Crematory 4 Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funer Service License 20904 11800 New Hampshire Avenue; Silver Spring, MD 23a. Part. Enter the dilease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fourse. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Intra cerebral /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an cate has by page 2 s performed 2 1No certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending 1 Natural 5 Pending investigation in 24 hours after the function of the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 [P Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ပ 10 31 2007 1821200(10 MD Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE, PRINCE PHILIP OLNEY 31. Date filed (Month, Day, Year) 32 egistrar's Signature State 2007 Registrar

			For State Registrar	State of Ma	aryland /		artment of H rtificate of L		ana ivie				
	ALC: U		Registrar 1. Decedent's Name (First, Middle	, Last)		061	tineate of L	Jean	2	2 Date of Dec	Reg. No.	2001	3. Firme of Death
	Physicia /Medic		Lloyd	Allen			Ritchie			Novemb	er	Year 8, 2007	5:00 A M
	Examin		4a. Facility Name (If not institution				4b. City, Town, or				4c.	County of Death	
	%	A	14304 Old Oldt 5. Social Security Number		e (In yrs. last	birthdav)	Spring			3. Date of Birt	h	Allegar 9.Birthp	lace (State or Foreign try)
	Funeral Director		235-52-5101	11731 M 2□ F	74	Yrs.	Months Days	Hours	Min.	(Month, Day 02/22/	y, Year)		
1	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation						0d. Inside City Limits
	// Aaryla	o		egany	Too. Oily, 1		ing Gap						1 ☐ Yes 2 No
	r 28a- notifi	Director	10e. Street and Number				10f. Zip Code				10g. Cit	izen of What Coun	try?
	th with		14304 Old	Oldtown Roa	d		2156					USA	
	within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Ori in, Mexicar	gin? (Spec i, Puerto R	ify Yes or No- ican, etc.)	-	 Race - Americ Black, White, 	
30	rs afte	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates.	rean .	ra	1 ☐ Yes 2 🙀 No	2 No Specify:				Specify:	<i>l</i> hite
5-0036	72 hou natura ical E		15. Decedent	's Education	war Ei	6a. Dece	dent's Usuai Occupa	ation	t of working	,	16b. K	ind of Business/Ind	
7	ithin 7 ne. nan "r Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		kind of work done of DO NOT use retired		t or working		,		
7	it ibe	ဝိ	12 17. Father's Name (<i>First, Middle,</i>	Last)		(Glass Cut		er's Name	(First, Middle,		Plate Gla Surname)	ISS
Maryland	be od o	o Be	Perry	Aldine		Rit	chie	-	erine			Irene	Wince
ary	should and Men s marke umatic	-	19a. Informant's Name/Relations	nip (Type. Print)	1	19b. Mailir	ng Address (Street	and Numbe	er or Rural	Route Numbe	er, City o	or Town, State, Zip	Code)
	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		Erna R. Ritchie	: / Sister			Box 5, S						
ore	Pages 1 nent of H int: If iter iny or oth		20a, Method of Disposition 1 ☐ Burial 2 🎇 Cremation				sition (Name of matory or other place	1	Da			ocation - City or To	
Baitimore,	permit. Page Department of Important: If any Injury of once.		4 □ Donation 5 □ Other (S		Cumbe		nd Cremato					mberland, Funeral	Home, P.A.
g	Department Department		MINOI X	Udama			104 Decat						21502
Г			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lir	d the death. E	o not ent	er the mode of dyin	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- Ender	AGe	me	tastatic	Car	Y	CAnc	2~		Onset and Death
18	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ce of):	1:	0					
е.	, a 😢	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as	a consequen	ce of):							
	cuted id	Examiner	that initiated events										
Ö,	e execian ar	EX	resulting in death) Last	Due to (or as	to (or as a consequence of):								
09/89	ificate be executed g physician and as the burial-transit	edical		d								+	
POX 6	= 50 00	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. if yes, outcome								23d. Date of delive	егу
	death e atter	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at			□Ectopic pregnancy □ Other (specify)	<i>'</i>				Month	Day Year
J.	at the I by th	hys	9 Unknown	9□Unknown		- 1		! 1		OO- Did A	-h		source of death?
	The law requires that the death certife has been signed by the attending age 2 should be detached for use a	Ď	Part II. Other significant condition	ns contributing to death b	ut not resultin	ıg ın the u	ndenying cause give	en in Parti	•	1 🗆 1		□ No 3□ Prot	ne cause of death?
Vital Records,	v requ	Completed								24a. Was			psy findings available
ĕ	he lav e has	dmo								auto; perfo	osy ormed?	prior to co death?	mpletion of cause of
Ţ		Be Co	25. Was case referred to medica					26. Place	e of Death	1□ Yes (Check only o	2 No ne)	1 □Yes	ZLINO
<u>o</u>	Physici this ce al direc	To B	examiner? 1 ☐ Yes 2 ☑ No		ent 2□ER			4 ⊔ NI				6 □Other (Specif	(y)
	ding Pr h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Date of Inju g (Month, Day		Bb. Time o Injury	Wor	yat k? Yes 2 □		8d. Describe	how inju	ry occurred	
Division	l or Attend after death Director:	icat	2 Accident investig	not be 28e. Place of inju	ury - At home	, farm, sti	reet, factory, office	res Z		8f. Location (Street a	nd Number or Run	al Route Number,
2	al or A safter il Dire	Certification:	4 ☐ Homicide determ	building, etc.	c. (Specify)					City or To	vn, Stat	e)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,			ng Physician: To the best Examiner: On the basis o									
	To the H within 24 To the F complete	Medical	one) 29b. Signature and title of reprine	and manner sta			29c. Licens					ate signed (Month,	
\		_	250. Signature and the object and	Iron on	m		T	7	218	7	- 1	1	A
	6+		30. Name and address of person	who completed cause of d	leath (Item 23	Ba) (Type,	Print)	00	10	1	100	V CMBC12	08,2007
	MAS		Gary L. Wa	agoner, M.D.	, 925	Bisl	nop Walsh	Driv	re, Cı	umberla	and,	MD 215	02
5	Sta Registr		31. Date filed (Month, Day, Year)		rar's Signatur		all o						

Medical 29b Signature and title of certifier November 12, 2007 O.C.M.E. Oryme met Inel 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Margarita Korell MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar **OCME** ORIGINAL DHMH 17 Rev 1/2001 **OCME 2006**

07-08362 Villiam Ronald Smo	otate of maryland / Department of 1	lealth and Mental Hygiene	ible.
Physician/ Medical Examiner	1- For State Certificate of E Requistrar 1. Decedent's Name (First, Middle,Last) William Smoot Sr.	2. Date of Death	Day Year 4000
	4a. Facility Name (if not institution, give street and number) 4b.	City, Town, or Location of Death Columbia	4c. County of Death Howard
Funeral Director	214-38-5910 txxM 2_F 66 Yrs.	If Under 1 Year If Under 24Hrs. 8. Date of Birth Months Days Hours Min. 2/17/1	n(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
e Maryland or 28a-f show any fied at once.	Usual Residence of Decedent 10a. State 10b. County Anne Arundel Crownsville		10d. Inside City Limits 1 Yes 2 XX No
h the Maryland 3a or 28a-f sho otified at once	10e. Street and Number 807 Old Herald Harbor Rd.	0f. Zip Code 10 21032	g. Citizen of What Country? USA
Baltimore, MD 21215-0036 permit Pages I and J should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 Married Armed Forces? If Yes, 1XX Yes 2 No	Decedent of Hispanic Origin? (Specify Yes or No- specify Cuban, Mexican, Puerto Rican, etc.) By Specify:	14. Race - American Indian, Black, White, etc. Specify: White
5-0036 ed vittin 72 hours tygiene. other than "nature the Medical Exami		of working life. DO NOT use retired)	16b. Kind of Business/Industry Construction
21215-0036 uld be filed within 7 Mental Hygiene. marked other than enerked other than for the Medical for Be Complé	17. Father's Name (First, Middle, Last) DeImar Smoot	18.Mother's Name (First, Middle, M Dorothy May Ogd	laiden Surname) len
MD 21 d 2 should dth and Men n 27 is man aumatic ev	Kimberly Grimes (Daughter) 652 Kim	ddress (Street and Number or Rural Route Numb nberly Way Stevensville	, MD 21666
Baltimore, permit. Pages 1 an Department of Hea Important: If iter injury or other tr	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition crematory or other Baldwin Men	place) norial 11/2/2007	20c. Location - City or Town, State Millersville, MD
Balt permit. Departi Import injury		ne and Address of Facility Hardesty Fu Ridgely Ave. Annapolis	. MD 21401
Physician /Medical Examiner	23a. Part I. Enter the disease for complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A Hypertensive Atherosclerotic Cardiov Due to (or as a consequence of):		st, shock, or heart Approximate Interval Between Onset and Death
iner	Sequentially list conditions.		
ecuted and transit al Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d		
760, cate be ex- physician he burial -	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
D.O. Box 68760, that the death certificate be exvented by the attending physician detached for use as the burial-by Physician/Medic.	past 12 months?	death 3 Ectopic pregnancy (Specify)	Month Day Year
s, P.O. inrest that the riggred by the detache ad by Predetache ad by Predetache.	Part II. Other significant conditions contributing to death but not resulting in the und		pacco use contribute to the cause of death? 2 No 3 Probably 4 ✓ Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transifiedical Certification: To Be Completed by Physician/Medical Es		24a. Was a autops perfor 1 Yes 2	sy prior to completion of cause of
Vital ysician: his certif director,	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	26.Place of Death (Check only one) Other Nursing Home 5 F	Residence 6 Other:
Division of Vispital or Attending Physical or Attending Physical or Attending Physical Director: After this of Attention of Attention of Attention of Attention of Attention of Attention of Attention of Visi	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	ry 28c. Injury at Work? 28d. Describe h	ow injury occurred
Divis pital or A ours after eral Direc filled in b	3 Suicide 6 Could not be 4 Homicide 6 Could not be determined (Specify)	factory, office building, etc. 28f. Location (S or Town, St	treet and Number or Rural Route Number, City ate)
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificatic	29a. Certifier (Check only one) 2	, in my opinion, death occurred at the time, date a	and place, and due to the cause(s)
a	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) October 28, 2007
154104		eet, Baltimore, MD 21201	
State Registrar		W	
DHMH 17 Rev 1/2001 OCME 2006	ORIĞINAL	OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 4:30 P^M oyc e Sh esidan 11/13/2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death North Hampton Manor Frederick er 1 Year | If Under 24 Hrs. | Frederick 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Months Hours 1 □ M 2 🔀 F 99 223-62-3871 MD <u>1/4/1908</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No **Knoxville** Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21758 4116 Weston Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin Adreon Sue Jovce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2853 Ontario Rd NW Apt 506 Washington DC 20009 Daughter Michael J. Sheridan 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Cremation 11/14/2007 Smithsburg, Maryland 21. Signature of Funeral Serve Lig 22. Name and Address of Facility Keeney & Basford P.A. F.H. MO1176 106 East Church Street Frederick, MD 21701 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral Director

Be Completed by

ဥ

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

physician and s the burial-trans

signed to page 2 n 24 hours after death.

The Funeral Director: A pletely filled in by the filled in th

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

State Registrar

Examiner	disease or condition resulting in death)	a. Due to for as in order	1 WE	P/K					
	Sequentially list conditions, if any, leading to immediate cause. Line, Uncerlying Cause (Disease or injury that initiated events	b							
	resulting in death) Last	Due to (or as a consected.	uence of):						
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 23d. Date of Month 5 □ Other (specify) 9 □ Unknown 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown								
	Part II. Other significant conditions of		ute to the cause of death? ☐ Probably 4 ☐Unknown						
	24a. Was an autopsy performed? 1 □ Yes 2 No 1 □ Y								
	25. Was case referred to medical	eath (Check only one)							
	examiner? 1 ☐ Yes 25 No	Hospital: 1 ☐ Inpatient 2 ☐	ecify)						
	27. Manner of Death Natural 5 Pending Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred			
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact	ory, office	t and Number or Rural Route Number, tate)				
edical C	29a. Certifier (Check only one) Certifying Physics 2 Medical Example 2	ysician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurration and/or investigation	ed at the time, date and pla on, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner a and place, and du	s stated. te to the ca	use(s)	
Je .	OOL Oi-pate And title of partifier			29c License number	004 1	Note signed (Man	th Day V		

DHMH 17 Rev 1/2001

within 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		For		State o	f Marylan	d / Depa	artment of I	Health a	and Mer	ntal Hygi	ene			
						Cei	rtificate of	Death	Reg	Reg. No. 2 0 0 7 3 7 1 7 8				
Physicia	an	1. Decedent's Name	e (First, Middle	e, Last)						2. Date of Death Month Day		ear	3. Time of Death	
/Medic		Georg			Henry		Smit		N	ovembe	v072	(00)	0025	
Examin	er			, give street and nu			4b. City, Town,	or Location of	of Death			ounty of Death		
Maria de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de		5. Social Security N		nty Hospi	7. Age (In yrs.	last hirthday)	Hagers If Under 1 Year		24 Hrs. 8.	Date of Birth	Wash		on ace (State or Foreign	
Funeral Director	Funeral Director	220-16-07	763	6. Sex 1 M 2 □ F	80		Months Days		Min.	(Month, Day, 1)	rear)	Count	ry)	
4 144		Usual Residence of	Decedent						130	IIIE 24,	194/ 1		land	
arylan show		10a. State	10b. County		10c. City	y, Town or Lo	cation					10	d. Inside City Limits	
Ba-f s		MD		ington	Вос	onsbor							1 ☐ Yes 2 M No	
with the		10e. Street and Nur					10f. Zip Code							
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fter d r item iner	Fun	 Marital Status Never Marr 	ied 2□ Marri	Armed Fo	orces?		Was Decedent of If Yes, specify Cul			an, etc.)		White, e		
urs a al', ol Exam	Completed by I	3 X Widowed		If Yes, Gi Year or D	ve Dates:		1 □ Yes 2 🖾 No	Specify:			Specify:	Whi	te	
72 ho natur fical i		(Spec	15. Decedent	's Education st grade completed)		16a. Dece	dent's Usual Occu	pation	st of working	1	6b. Kind of Busin	ess/Ind	ustry	
ithin ne.	nple	Elementary/Seco		College (1-4or 5+)	life. I	DO NOT use retire	ed)			*****			
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ntal H ed ot ed ot ever														
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nd 2 s Ifth ar 27 ls r trau				hart/Dau	phter		Fairplay							
f Healifem		20a. Method of Disp	position		20b. P	Place of Dispo	sition (Name of matory or other pla	1	Date		0c. Location - Cit		vn, State	
Page lent o nt: If		1 ☐ Burial 2] 4 ☐ Donation		3 □Removal from pecify)	State			· /	1/10/2	2007 S	mithsbui	rg.	MD	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumattc event, the Medical Examiner must be notified at once.		4□Donation 5□Other (Specify) Smithsburg Crematory 11/10/2007 Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel												
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		23a. Part1. Enter the disease, or complic of a sithat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of use on each line. Approximate Interval Between											Interval Between	
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w requires that the d been signed by the should be detached		Part II. Other signi	III A J	Sul Out to	leath but not resi	uiting in the u	nderlying cause g	Mak	0-	23e. Did toba		Prob	e cause of death? ably 4 □Unknown	
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e law has b	mple									24a. Was an autopsy perform	pric	re autor or to con ath?	osy findings available apletion of cause of	
Th icate r, pag							and the same of th			1□ Yes 2	4 40 1		2 □ No	
siciar certif recto	Be c	25. Was case referexaminer? 1 ☐ Yes 2 ☐		Hospital:	Innationt 277	ER/Outpatier	* 3 T DOA O	her		heck only one				
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th. :: Afte	tior	27. Manner of June 28a. Date of Injury 28b. Time of Injury 1 28c. Injury at Work? 2 Accident investigation 28c. Injury at Work? 1 Yes 2 No												
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tal or s afte al Dir ed in	Certification:	4 Homicide Sold-Initial Building, etc. (Specify)												
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
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N T N	<							29d. Date signed (Month, Day, Year) 36655 MN. & 2007 HAGURIFORN, MD 2174C						
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Sta	te	31. Date filed (Mor	oth, Day, Year)	32. F	Registrar's Signa	ature	1	1	, , , ,		2 . 4			
Registr			NOV O	9 2007	Messer .	A. F	certa							
	_					2"							_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Catherine oct 21 2007 \mathbf{E} Steinbuch - 0 TA.M /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Calvert County Nursing Center Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Jahon b Days 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□ M 2□ F 90 098-10-0638 New York Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at St. Leonard Maryland Calvert 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20685 3125 Lloyd Bowen Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married _{Specify}white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic evance. Dora Gerald Charles Nielsen ဥ 19a. Informant's Name/Relationship (Type. Print)
William Steinbuch - son 19b. Mailing Address (Street and Number or Rural Route Number, City or Jawn, State Zin Code)
3125 Lloyd Bowen Rd. St. Leonard, MD 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) Ct 23 2007
Metropolitan Funeral Service 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition DISEASE Lais ARTER CORONARY Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any series in the immunity cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy perform this certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier wish 19427 Allendi

State Registrar ANWAR

31. Date filed (Month, Day, Year)

NOV 0 2 2007

DHMH 17 Rev 1/2001

110 HOSP RD. PRINCE FREDERICK

30. Name and address of person who completed cause of eath (Item 23a) (Type, Print)

MUNSHI. M.D. SUITE 303

32. Registrar's Signature

7-08	809 el Douglas	: Sai		e or Print in ate of Maryla						egibl	e.			
iiona	or Douglas		1- For State Registrar				of Death	and Men	arriygiche	Reg. No	21	n	7 3	718
Madi	Physician/ 1. Decedent's Name (First, Middle,Last)								2. Date of D Month Novemb		Year		3. Time of De 0903 hr	
vieur	cai Lxaiiii		MICHAEL DOU 4a. Facility Name (if not institution				4b. City, Town	, or Location of			c. County of	Death		
	1		207 East Heather Roa				Bel Air				Harford	0.5:		
	Funeral Director		5. Social Security Number 212–94–1925		7. Age (In yrs. I	_		Year If Under Days Hours	Min. Aug.	,	1	Foreign	nplace (State intry) Mar	
	Birector		Usual Residence of Decedent	1 XM 2 F		J Y	rs.		Aug.	27,	1712		may/ Plair	yrand
	r any	Ì	10a. State 10b. County	-	,	Town or Loc	ation						10d. Inside (•
	Aaryland 28a-f show I at once.	tor	Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Count										Z XIVO	
7	ith the Maryland 23a or 28a-f sho notified at once.	Director	207 East Hea	ther Road		2101			USA			,-		
\geq	with t ms 23a be not		11. Marital Status	12. Was Dec	edent Ever in U		Vas Decedent of	Hispanic Orig	in? (Specify Yes or Puerto Rican, etc.)				can Indian, B	ack,
	r death or ite	Funeral	*	Armed Fo				ruello ricali, etc.)				21		
	urs afte tural",	ρ	3 Widowed 4 Div	orced If Yes, Give Yea or Dates: cify only highest grad		16a. Deced		upation (Give k	kind of work done	16b.	Specify: Kind of Bus		ite ndustry	
•	72 hor an "nai cal Exa	letec	Elementary/Secondary (0-12)	College (1	-4 or 5+)	during	most of working	life. DO NOT	use retired)					
Š	21215-0036 Juld be filed within 77 Mental Hygiene. marked other than	Completed	17. Father's Name (First, Middle,	4		Chef		18 Mother	's Name (First, Middl		Restau	ran	t	
7	Z13- ce filed ntal Hyj ked of	Be C	Richard Dougla	•					ina Jean C					
	e, MD Z1Z1 1 and 2 should be fi Health and Mental item 27 is market		19a. Informant's Name/Relations			4.0	,		ber or Rural Route		•			
	and 2 she ealth and tem 27 is traumat		Richard D. Sat 20a. Method of Disposition	ntora /Fa			East He position (Name o		Road, Bel		Location -			
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeric House I filed pages I is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation		On State	crematory or		Com	11-15-07	,	or recon	Мэ	ryland	i
			21. Si Yur of Funeral Service		1117				Home, P.		JWSOII,	Pict	Lyland	
			1317 Cokesbury Road, Abingdon, Maryland 21009											009
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, failure. List only one cause on each line.									nock, or nea	rt	Between 6	Onset and		
	taminer		Immediate Cause (Final disease or condition resulting in death)		consequence of								1	
		<u>.</u>	Sequentially list conditions, b											
		Examiner	(Disease or injury that initiated											
	ecuted and transit		events resulting in death) Last Due to (or as a consequence of):											
	, oe exec ician ar irial - ti	dical	X UNPENDED	AMENDED #23a.P	II.27.28a	-f. per	ME . g873. 1	11/27/07	TT					
5	BOX 68/6U, re death certificate be exe the attending physician in ed for use as the burial -	≒	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes,	outcome of preg	gnancy	Fetal death		c pregnancy	2	23d. Date of Month		/ Day	Year
Ž	SOX 68 leath certifi e attending for use as		past 12 months? 1											
Ċ	that the deaned by the a	Phys	Part II. Other significant condit	a Clikii		resulting in th	e underlying cau	use given in Pa	art I. 23e. D	id tobacc	co use contri	bute to	the cause of	death?
	DIVISION Of VITAL RECORDS, P.O. Ital or Attending Physician: The law requires that the rate death. After this certificate has been signed by led in by the funeral director, page 2 should be detach	>	Cocaine use		_					Yes 2	No 3	Pro	oably 4 🗸	Unknown
-	DIVISION OF VITAI KECOTOS, Pipital or Attending Physician: The law requires ours after death. After this certificate has been sign filled in by the funeral director, page 2 should be.									utopsy	P	rior to	topsy finding completion of	s available cause of
	tal Reco cian: The law certificate has ector, page 2 s									erformed es 2		eath?	es 2	No
	ician: s certifi rector,	Be (25. Was case referred to medica examiner?	Heenitel:	Inpatient 2	ER/Outpati		Place of Death Other	(Check only one) Nursing Home 5	Peri	dence 6	Othe	r: Scene	
	Of VI	-: To	1 ✓ Yes 2 No 27. Manner of Death	28a, Date		28b. Time		Injury at Work			njury occurre		i. occiio	
	IOD tendin leath. tor: A the fu	Certification:	1 Natural 5 Pend 2 Accident Inve		11/13/200	7 Fnd 9	:00 am 1	Yes 2	5 V2.5					
	NVISIOR I or Attence after death Director: d in by the	rtific	3 Suicide 6 X Could not be determined (Specify) Sound at home 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found at home 28f. Location (Street and Number or Rural or Town, State) 207 E. Heather Rd. Bel											
	Lospita Hospita A hours Tuneral	. –	4 Homicide determined (Specify) FOUND at nome 207 E. Heather Rd. Bel Air, MD 29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										ש	
	DIVISION Of VITAL RECORDS, P.O. BOX 68/60, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	F S F S	Me	29b Signature and title of certific	29c. Li	29d. Date signed (Month, Day, Year)									
			30, Name and address of person who completed cause of death (Item 23a)							November 14, 2007				
			Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
		tate	31. Date filed (Month, Day, Year)	2007 32 R	egistrar's Signa	ture	and s							
	Regis	ueli	NOVAU	LUUI Code	in the state of the	100	and the same of th							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:52 PM 2007 GENE HENRY THOMPSON, JR. 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S DOCTOR'S COMMUNITY HOSPITAL LANHAM 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/12/1944 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Hours 1**XX**/ 2□ F Months Days WASHINGTON, DC 63 Director 579-56-5678 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1XXYes 2 □ No Director DC WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3914 4TH STREET SE APT. #202 20032 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No BLACK Specify by 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE ELECTRICIAN YEARS Department of Health and Mental Hygie Important: If item 27 is marked other i any Injury or other traumatic event, ± 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be Health and Mental GENE HENRY THOMPSON, SR. LILLIE MAE WATSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1614 FOREST PARK DR. DISTRICT HEIGHTS, MD 20747 GENE HENRY THOMPSON, III/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 11-07-2007 TRIANGLE, VIRGINIA QUANTICO NATIONAL 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sele consequence of Examiner Carcinomo certificate be executed and burial-trar Due to (or as a consequence of) attending physician Physician/Medical the as esn If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ę Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ neumin. 2 No 3 Probably 4 Unknown Completed peen: 24a. Was an page 2 s has autopsy performe certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Depatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 2 this 27. Mann of D funeral of Death 28a. Date of Injury 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: (Month, Day Year) Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

the within 2.

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

NOV 0 5 2007 32. Registrar's Signature

29b. Signature and title of certifi

and manner stated.

impleted cause of death (Item 23a) (Type, Print)

29c. License number

Good Luck Rd.

MBD60611

29d. Date signed (Month, Dav. Year)

Lanham, m.D. 20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 28 2007 LOUISE WHITMORE 1:20 A 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PRINCE GEORGE'S 6936 HANOVER PKWY # 301 GREENBELT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, DEC 5 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min 1 □ M 2 🕁 F SOUTH CAROLINA Yrs 250-54-1801 70 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No PRINCE GEORGE'S GREENBELT 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 6936 HANOVER PKWY # 301 20770 U.S.A. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: 1 ☐ Never Married 2 ☐ Married BLACK 1 ☐ Yes 2 No Specify. 3X Widowed 4 □ Divorced 16a, Decedent's Usual Occupation 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th College (1-4or 5+) NURSE AIDE PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, CALVIN WASHINGTON KATHLEEN HANNAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6939 HANOVER PKWY # 301 GREENBELT, MARYLAND DEMETRE WHITMORE/DAUGHTER 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) ARLINGTON CEMETERY 11/16/2007 ARLINGTON, VIRGINIA 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Malignant Neoplasm of brain 11 months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2▼ No 24a Was an autopsy performed? Yes 2 No 1□ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Department of Health Important: If item 27 any injury or other to once.

Physician

/Medical

Examiner

Funeral

Director

a or 28a-f show the notified at

r than "natural", or items 23a the Medical Examiner must b

.. Pages 1 and 2 should be filed wittent of Health and Mental Hygien tant: If Item 27 is marked other the ijury or other traumatic event, the

Director

Funeral

3

Completed

Be

2

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

physician and s the burial-transit requires that the death certificate be executed as attending nse s for the signed by the been has

Box 68760.

P.O.

Division or Vital Records,

Physician:

page 2 certificate After this funeral Hospital or Attending | the

State Registrar

Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Completed 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1X Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064178 October 31, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harvinder Singh M.D 110 Irving Street N.W. Washington DC 20010

32. Registrar's Signature

NOV 0 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year

Physician /Medica Examine

1 - For State Registrar

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amp injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Stat

Registrar

	Eva	June Watkins-B	ull				Novembe	r 1, 20	007 8:45	A M	
r d	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of	f Death		4c. County			
	619 Beach Driv	e		Anna	apolis	3		Anr	ne Arundel		
1	5. Social Security Number 6. S	0 . ,	ast birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State Country)	or Foreign	
	232-34-7465	□ M X X F 78	Yrs.	Wierians Days	riodis		June 17	.1929	West Virg	inia	
	Usual Residence of Decedent										
	10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside (
2	Maryland Anne	Arundel		Anna	olis				1 □ Ye	s 2 X Xo	
≺ ⊢	10e. Street and Number			10f. Zip Code	<u> </u>		10	g. Citizen of V	What Country?		
5	610 Ros	ch Drive		2140	13			United	States		
		12. Was Decedent Ever in U.S	2 12 1			in? (Cno	oifu Voc or No		e - American Indian,		
<u> </u>	11. Marital Status	Armed Forces?	3. 13. V	Was Decedent of H f Yes, specify Cuba	an, Mexican,	, Puerto F	Rican, etc.)		ck, White, etc.		
<u>_</u>	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes ★ No If Yes, Give X	1	1 □ Yes XX No	Specify:			Specify	V: 171-1		
3		Year or Dates:	10 0					AL 10 1 1B	White		
completed by	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Give	lent's Usual Occup kind of work done DO NOT use retired	ation during most	of working	ng I	16b. Kind of Bu	usiness/Industry		
-	Elementary/Secondary (0-12)	College (1-4or 5+)						Fodorol	l Governme	nt	
3	L	4	Adill	nistrato						1111	
D I	17. Father's Name (First, Middle, Last)						(First, Middle, N	faiden Surnan	ne)		
	Loris Rupert Hudd	Leston			Eva	Bown	an				
	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street	and Number	r or Rura	l Route Number,	City or Town,	State, Zip Code)		
	Diane E. Adams /	Daughter	619 B	each Dri	re An	napo	lis, Ma	ryland	21403		
-	20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of natory or other plac	20)	D	ate 2	20c. Location -	City or Town, State		
	1 ☐ Burial 3 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Intellioval Holli State		Cremator	1	1//./	2007	altimo:	re, Cremat	orv	
i	21. Signature of Funeral Service Licer		CTHIOL 6	Name and Addre	s of Facility	1/4/	n M Ta	wlor F	uneral Hom	e Inc	
	21. Signature of Furieral Service Licer	D /	1		of Cla	301	m m. la	Appon	olis, MD 2	1/01	
+	11 Wela Cf	Vien									
	23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not ente	er the mode of dyir	ig, such as c	cardiac o	r respiratory arre	est,	Approxima Interval Be	etween	
ľ	Immediate Cause (Final	BROACT	CF	MIER					Onset and	ARS	
disease or condition resulting in death) a. Due to (or as a consequence of):											
<u>.</u>	Sequentially list conditions, if any leadin, to immediate	b Due to (or as a consequ	ience of):								
	Cause. Enter Underlying Cause (Disease or injury										
Y	that initiated events resulting in death) Last	C Due to (or as a consequ	ence of):								
2											
siciall/Medical Examiner		d									
	IF FEMALE:	220 If you outcome of progra	nov								
	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy	,				te of delivery onth Day	Year	
2	1 ☐ Yes 2 No	4□Pregnant at time of de 9□Unknown	eath 5□	Other (specify)				.***			
<u> </u>	9 ☐ Unknowň						00- 511			r 1#- C	
2	Part II. Other significant conditions of	ontributing to death but not resu	iiting in the ur	nderlying cause giv	en in Part I.			. 1	tribute to the cause of		
completed by							1 🗌 Ye	s 2 No	3 ☐ Probably 4 ☐	Unknown	
							24a. Was ar	24b.	Were autopsy finding	s available	
É '	· · · · · · · · · · · · · · · · · · ·						autops perform 1⊟ Yes 2	y [prior to completion of death?	cause of	
	25. Was case referred to medical				00 FI	-4.0	-1-		1 ☐ Yes 2 No		
3	examiner?	Hospital;	ED/0-1- "	t 3DDOA Oth	or.		(Check only one		DAGG	C125	
2 -	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	I JUDON	4 LI Nur		ne 5 Reside		ner (Specify)	NE	
5	1 ANatural 5 ☐ Pending	(Month, Day Year)	Injury	Wor			.ou. Describe no	w mary occur	100		
Celulicanon	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□N						
	4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, tarm, stre /)	eet, factory, office		2	8f. Location (St. City or Town	reet and Numb , State)	ber or Rural Route Nu	ımber,	
	29a. Certifier 1 Certifying Ph	ysician: To the best of my know niner: On the basis of examinat	wledge, death	n occurred at the till	ne, date and	d place, a	and due to the ca	ause(s) and ma	anner as stated.	e(s)	
Medical	one)	and manner stated.				5000110	w. and anne, U	and place,	and doo to the cause		
Ä	29b. Signature and title of certifie	3) 61 1		29c. Licens	e number		29	d. Date signe	ed (Month, Day, Year)		
	Whether !	(O/12 (IA))		Wi60	64			11/10	7		
	30. Name and address of person who	completed cause of death /Item	23a) (Tvne	Print)	-10						
	VISI PRANCINI	1 QUARTITA	2.121	ZIM A	m ran	100	(W)	1714	101		
	31. Date filed (Month. Dav. Year)	2. Registrar's Signar	ture	300	110,11	UVE	4	5 -1	10)		
	31. Date filed (Month, Day, Year) NOV 0 2 2007	Show It	ha	1. 0							
		1	19								

1 - State Registrar

			1 - State Registrar			Cei	rtificate	e of L	Death			Reg. No. 🤈	דחר	27101
Н		Э	1. Decedent's Name (First, Middle	e, Last)							2. Date of De Month	ath Day	Year	3. The of Deale
3	Physicia /Medic		Jesse		ļ	VII	son				october		2007	04:45 M
į.	Examin		4a. Facility Name (If not institution	n, give street and number)			_		Location of			4c. County	of Death	
A BY		=6	Johns Hopkin						ore				/A	
b	Funeral Director	1	5. Social Security Number 218-84-7862	6. Sex 7. Age	(In yrs. last birt		If Under Months	1 Year Days	If Under 2 Hours	A dian	8. Date of Bird (Month, Da Apr 6	y 1964	9. Birthp	lace (State or Foreign try) Land
, Š.			Usual Residence of Decedent		1 1							27 10 10	1	
	yland now at		10a. State 10b. County		10c. City, Town	or Lo	cation						1	0d. Inside City Limits
	a-f sh	١ڟ	Maryland Anne	Arunde1	Seve	rn	a Pai	rk						1 □Yes 2X No
	or 28.	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cour	itry?
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	ems er m	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Nas Deced	lent of Hi dify Cuba	spanic Orig n, Mexican,	in? (Spe Puerto l	cify Yes or No Rican, etc.)	. 14. Ra Bla	ce - Americ	
36	J within 72 hours after death with the Marylar jiene. Jene. Than "natural", or items 23a or 28a-f show it he Medical Examiner must be notified at	by Fu	1 Never Married 2 Marr	If Yes, Give	0		1□Yes }						бу: В 1 а	ıck
5-0036	hours tural'		3 ☐ Widowed 4 ☐ Divorced		169	Decer	dent's Usua	d Occups	ation			16b. Kind of E		
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Maryland 2121	e d at b	To E	George J. Wil	lson					Shi	rle;	y Broo	oks		
ar _{>}	nd 2 should lith and Men 27 Is marke r traumatic		19a. Informant's Name/Relations	hip (Type. Print)	19b.	Mailir	ng Address	(Street a	and Number	r or Rura	l Route Numb	er, City or Town	, State, Zip	Code)
_	s 1 and f Health item 27 other tr		Sandra A. Wil	lson(Wife)					ngs			na Par		
ore	Pages 1 nent of H int: If Iter iny or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐Removal from State		y, crer	natory or o	ther plac			ate	20c. Location		
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Baltimore,	permit. Pages Department of I Important: If Ite any Injury or o		21. Signature of Funeral Service		111183	- 1						iary, l s, Md.		11
			23a. Parl 1. Enter the dilease, or	2. Deen M		-	_				-		2140	Approximate
			shock, or heart failure. List	only one cause on each lin	e.	ot ent	ei tile illoui	e or dynn	g, suon as c	oai diac o	respiratory a	11631,		Interval Between Onset and Death
j.	Physician /Medical		disease or condition resulting in death)	a. <u>Se-01</u>	7 C Sh	30	CK						-	24 hours
	Examiner							12 1-	L	000	mia			2 Days
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	cuted id ransit	Examin	Cause (Disease or injury that initiated events	· Am	consequence	515	S .							one year
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л. О	the de	Physician	1 ☐ Yes 2 ऒ No 9 ☐ Unknown	9 Unknown	une or deam	JL	1 Other (sp	ecity/						
J	The law requires that the death certif the has been signed by the attending age 2 should be detached for use a		Part II. Other significant condition	ons contributing to death bu	t not resulting in	the u	nderlying ca	ause give	en in Part I.		23e. Did t	obacco use cor	ntribute to t	ne cause of death?
g	quires n sign	d by									1 🗆	Yes 2 No	3 ☐ Prot	pably 4 □Unknown
ပ္ပ	s bee	lete									24a. Was		. Were auto	psy findings available
ř	The lay te has age 2	Completed									auto perfo 1 Yes	ormed?	death?	mpletion of cause of 2 ☐ No
Vital Records,		Be C	25. Was case referred to medica	I					26. Place	of Death	(Check only		1000	2010
>	nis ce direc	To E	examiner? 1 □ Yes 2 ☑ No	Hospital: 1 Impatier	nt 2 ER/Out	patien	it 3□ DO	Othe	er: 4 🗆 Nur	rsing Hor	ne 5 Resi	dence 6 🗆 Ot	ther (Specil	(y)
0	ng Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Date of Injur (Month, Day		ime of	f 2	8c. Injury Work	y at c?	2	28d. Describe	how injury occu	rred	
<u> </u>	tendl eath. tor: A the fu	catio	2 Accident investig	gation			М		Yes 2□N					
DIVISION OF	or At fiter d Direct in by	Certification:	4 Homicide determ		ry - At home, fai . <i>(Specify)</i>	m, str	eet, factory	, office		2	28f. Location (City or To		ber or Rura	al Route Number,
	spital ours a neral l		29a. Certifier 1 🗸 Certifyir	ng Physician: To the best o	f mv knowledge	. deatl	h occurred	at the tin	ne. date and	d place.	and due to the	cause(s) and n	nanner as s	stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical		Examiner: On the basis of and manner sta	examination an									
	To th Within To th	Me	29b. Signature and title of certifie	r			290	. License	e number			29d. Date sign	ed (Month,	Day, Year)
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	,000pg													
	HE		Fasika Woreta, J	Johns Hopkins 1	tospital,	600	Nort	6WC	offe St	Heet	Bullin	rore, Mi	arylar	d 21287
	Sta Registr		S1. Date filed (Month, Day, Year)	2007 32. Registra	r s Signature									
DHI	MH 17 Rev 1/20		30. Name and address of person Fasika Woreta, J 31. Date filed (Month, Day, Year) NOV 0 5	LUUI JUGGER	J. J.	4		•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Mar	•	artment of F <i>rtificate of I</i>			giene Reg. No. 2 A A ~	7 27195
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	3. Time of Death
	/Medic		Margaret Weidle 4a. Facility Name (If not institution, give sta			4b. City, Town, or	r Location of Death	October	4c. County of Deal	0.40 A
1000			Brighton Gardens A			Columbia If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	Howa	
	Funeral Director		5. Social Security Number 6. Sex 1	M ONE	(In yrs. last birthday) Yrs.	Months Days	Hours Min.	(Month, Day	(Year) Co	thplace (State or Foreign ountry) St Virginia
	land t		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mary la-f sho tifled a	ctor	Maryland Charles			Waldo	rf			1 ☐ Yes 2 No
	with the la or 28	Director	10e. Street and Number 222 Middleton Road			10f. Zip Code	20602		10g. Citizen of What Co USA	ountry?
	r death	Funeral		2. Was Decedent Ev Armed Forces? 1 Yes 2 No	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No- o Rican, etc.)		
39	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notifiled at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
21215-0036	72 hou "natura	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	king	16b. Kind of Business	/Industry
2121	d within giene. r than " the Med	dmo	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Guida	nce Couns			Education	on
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	
Maryland	2 should be in and Mental is marked or raumatic eve	7	Percy Paul Pharr 19a. Informant's Name/Relationship (Type	e. Print)	19b. Maili	ng Address (Street		aret McE	r, City or Town, State, 2	Zip Code)
	s 1 and 2 and 1 and 2 and 1 an		Patty L. Branch - D	aughter			d Court,		e, MD 2107	
altimore,	Pages 1 nent of H ant: If ite ury or ot		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State		unatory or other place U.M. Cem		Date -5-07	20c. Location - City or Dentsville	
Baltii	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	MODI)53 2	2. Name and Addre	ss of Facility	3035 0	old Washing of, MD 2060	ton Road
Ī.			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the cause on each line.						Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		Vascular consequence of):	Accident				Onset and Death 5 yrs
	Examiner		Sequentially list conditions b.	Due to (or as a t	consequence or).					
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68760,	icate by physic s the bu	edical	_d.							
Box	death certificate be executed e attending physician and of for use as the burial-transit		23b. was decedent pregnant	c. If yes, outcome pf 1 ☐ Live birth 2		⊒Ectopic pregnancy	/		23d. Date of de	
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	ires that the de signed by the a I be detached f	by Ph	Part II. Other significant conditions cont		not resulting in the u	ınderlying cause giv	en in Part I.		obacco use contribute to	
Sord	w require been sis		Essential Hyper	tension				1 L Y		robably 4 Unknown
al Re	The lar	Completed			- TA - TA			autop perfo		utopsy findings available completion of cause of
r Vit	Physician: r this certifica ral director, I	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	2 ER/Outpatie	nt 3 DOA Oth	OF:	th (Check only o	ne) lence 6 🖰 Other (Spe	Assisted
0 UC	ling Ph After th funeral	ion: T	27. Manyer of Death 1 V Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	/ear) 28b. Time o	Wor			now injury occurred	Living -
Division or Vital Records,	l or Attending after death. Director: After in by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	- At home, farm, st (Specify)		ies Z 🗆 NO	28f. Location (S City or Tow	Street and Number or R vn, State)	ural Route Number,
_	spital hours ineral y filled	Medical Ce			xamination and/or in		cause(s) and manner a date and place, and du			
	To the Howithin 24 In To the Fu	Me	29b. Signature and title of certifler	10	m.D.	29c. Licens			29d. Date signed (Mon	
)			P CO Nome and address of	Mr.		D565	31		Oct. 31,	2007
_	JB12		30. Name and address of person who con Harry Li, MD, 8600	Snowden R	iver Pkwy		01, Colu	mbia, MD	21045	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	1			-	

			For State	State of Ma	arylan	-	artment c rtificate			-	•	000-	7 071	00
			Registrar 1. Decedent's Name (First, Midd.	le Last)		Cel		UI Dec	3111	2. Date of De	Reg. No	.200	3. Time of D	Death
п	Physici			ancis Whee	1 or				N	Month	Da	y Year 2007		
	/Medic Examir		4a. Facility Name (If not institution		TEL		4b. City, Tov	vn, or Loca	tion of Death	lovembe:		. County of Dea	9:00A	<u> </u>
	-Admin		17800 Duvall D	rive			Соъъ	Islar	nd			Charles		
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. I	last birthday)	If Under 1 Y Months Da	ear If U	Inder 24 Hrs.	8. Date of Bir (Month, Da	th		thplace (State or ountry)	Foreign
п	Director		220-38-1941	MAJM 2LIF	66	Yrs.		4,0		ember :			aryland	
	w		Usual Residence of Decedent 10a. State 10b. County	,	10c, City	y, Town or Lo	cation						10d. Inside City	/ Limits
	Maryl f sho led a	ō	MD Cha	1		0.11	r . 1 1						1 □ Yes	
	the 28a-notif	Je C	10e. Street and Number	ırles		CODD	Island 10f. Zip Co	de			10g. Cit	tizen of What C	ountry?	
	3a or	<u></u>	17800 Duva11	Drive			20	625				USA		
	deatl	ner	11. Marital Status	12, Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Decedent	of Hispani	ic Origin? (Spe	ecify Yes or No)-	14. Race - Ame		
9	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 🗶 Mar	rried 1 ☐ Yes 2 📆	No		1 □ Yes 2.53		ecify:	ricall, etc.)		Black, Whi		
21215-0036	nours ural",	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					J. J. J. J. J. J. J. J. J. J. J. J. J. J				white	
<u>5</u>	"nati	lete	15. Deceder (Specify only highe	nt's Education est grade completed)	1	(Give	dent's Usual O kind of work d DO NOT use re	one durina	most of worki	ing	16b. K 	(ind of Business	/Industry	
12	withir ene. than he M		Elementary/Secondary (0-12)	College (1-4or 5	5+)		Excavat	,			Ι,	Constru	ation	
9	filed Hygi other ent, t	Be	17. Father's Name (First, Middle,	, Last)			Incavat		Mother's Name	(First, Middle			361011	
Maryland	3.2 should be filed within h and Mental Hygiene. 7 is marked other than " traumatic event, the Mec	To B	Francis Laurie	Wheeler				G1	Ladys R	. Posey	7			
ary	shou and N s mar	-	19a. Informant's Name/Relations	1 1 77		19b. Mailir	ng Address (St					or Town, State,	Zip Code)	
	Health tem 27 i	1	Frances P. Moo	dy/Wife		17800) Duval	1 Dri	lve,Cob	b Islar	nd,M	D 2062	ō	
Baltimore,	es 1 of He fiten		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 DRemoval from State	20b. P	Place of Disponentery, creation	sition (Name o	of r place)		Date	20c. L	ocation - City or	Town, State	
Ë	Pages ment of hant: If ite		4 □ Donation 5 □ Other (Specify)					em. 11			rlotte I	Hall,MD	
Salt	10a. State 10b. County 10c. City, Town or Location 10c. City, Code 10c. City, Co										P.A.			
	0 0 = @ O		Variet 1. (in	danson fr			211 St.	Mary	T'S AVA	I 2 P1	ata	MD 20	646	
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	t only one cause on each li	the death ne.	n. Do not ent	er the mode of	f dying, suc	ch as cardiac o	or respiratory a	rrest,		Approximate Interval Betw Onset and De	een .
權	Physician		Immediate Cause (Final disease or condition resulting in death)	a.	w.								days)
	/Medical Examiner		rosuming in assum,	Due to (or as	a consequ	uence of):							1.111/1	^
		ja	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	uence of):		-					ween	
	uted d ansit	듩	cause. Enter Underlying Cause (Disease or injury that initiated events	Stu	sis i	Ulce	- inh	ecto	71				mont.	S
oʻ.	exec an and rial-tra	Examiner	resulting in death) Last	Due to (or as	a consequ	uence of):				1				
38760,	ficate be executed physician and s the burial-transit	dical		c. Stu Due to (or as	uph	ual	Vasci	May	lder	ease				
w.	rtifica ng ph as th	Med	IF FEMALE:	1	•									
Box	leath certific attending p I for use as 1	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐Live birth	2 Fetal	Ideath 3	Ectopic pregr	nancy			-	23d. Date of de Month		ear
	ne dea the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of de	eath 5	Other (specif	fy)				WOTH	Day 1	Jui
P.0	that the de ned by the a detached f		Part II. Other significant conditi	ions contributing to death b	ut not resu	ulting in the u	nderlying caus	e given in l	Part I.	23e, Did 1	tobacco	use contribute t	o the cause of de	ath?
Division or Vital Records,	The law requires that the death certifite has been signed by the attending lage 2 should be detached for use as	Completed by	Δ .	Renal Faile						10	Yes 2	□No 3□P	robably 4 □Ui	лk no wn
Ö	w req beer shou	lete	Concertie	Heart 40	1611	10				24a. Was	an	24h Were a	utopsy findings a	vailable
Re	he law e has ige 2 s	E G	Nie to the	- 11 way 1 w	rev	<u> </u>				auto perfo	psy orm <u>e</u> d?	prior to death?	completion of ca	use of
ta		ပ္	25. Was case referred to medica	al I				26	Place of Death	1 Yes ∩ (Check only o	2 X No	1 □Yes	s 2□ No	
>		To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatie	ent 2 🗆	ER/Outpatier	it 3□ DOA	Other:				6 □Other (Spe	ecify)	
0	iing Phys I. After this funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Date of Inju (Month, Da	iry v Year)	28b. Time o	28c.	Injury at Work?		28d. Describe			,,,,,	
<u>Ö</u>	endir ath. or: Af he fur	atio	2 ☐ Accident invest	igation			М	1 ☐ Yes	2□No					
: <u>≅</u>	or Att	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ury - At ho c. <i>(Specif</i> y	ome, farm, str y)	eet, factory, of	fice	1	28f. Location (City or To	Street ar wn, State	nd Number or R e)	ural Route Numb	er,
	oital curs af		20 0 000		, ,									
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 ✓ Certifyi (Check only one)	ng Physician: To the best Examiner: On the basis of and manner sta	f examinal	wieage, aeat tion and/or in	vestigation, In	my opinior	ate and place, n, death occuri	and due to the red at the time,	cause(s , date an	and manner and place, and du	s stated. e to the cause(s)	
	o the ithin of the omple	Mec	29b. Signature and title of certific	All IIII	u.ou.		29c. Li	cense num	nber		29d. Da	ate signed (Mon	th, Day, Year)	
	⊢ ≯ ⊨ ŏ		· / ///	1/1/1/1/	>		7)464	119			11/5/		
			30. Name and address of person	who completed cause of c	leath (Item	23a) (Tvne	Print)		1			. / ~ / .		
Y	84		30. Name and address of persor Charline A Let 31. Date filed (Month, Day, Year NOV 0	tchford MO	404	Char	lei St	La 1	plata,	40 2	064	16		
	Sta		31. Date filed (Month, Day, Year) 32. Fegistr	ar's Signa	ture	outs							<u> </u>
	Registr	rar	NUV	2 TOOL CO	100	~ 19								

JD 1021

State 31. Date filed (Month Ony, Your) 5

Zabiullah Ali, M.D.

30. Name and address of person who completed cause of death (Item 23a)

2007

Assistant Medical Examiner

legistrar's Signature

111 Penn Street, Baltimore, MD 21201

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 1, 2007 November Emma Louise Wignall 8:25 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St. Mary's Nursing Center Leonardtown St. Mary's Hrs. 8. Date of Birth Min. April 1, 5, 1916 If Under 1 Year If Under Months Days Hours Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 91 1 □ M 2 X F Maine Director 579-34-8678 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland | St. Mary's Charlotte Hall Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 30025 Charlotte Hall Rd. 20622 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give permit. Pages 1 and 2 should be filed within 72 hours after a Department of health and Mental Hygiene. Important: If them 27 is marked other than "natural", or then any injury or other traumatic event, the Marianal Once. Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No White Specify. Specify. 2 Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker At Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Galen E. Ward Mary Jane Stevens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30025 Charlotte Hall Rd., Charlotte Hall, MD 20622 William L. Wignall, Jr./Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition Communication Communication Communication Communication Cardens 1 N Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State Nov. 6,2007 Waldorf, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 30195 Three Notch Rd., Charlotte Hall, MD 20622 moo81 the mode of dying, such as cardiat or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine r Atteriding Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a 23d. Date of delivery

attending physician for use as the buria Physician/Medical þ Completed has Be Medical Certification: To this After within 24 hours are dealt

To the Funeral Director:
completely filled in by the

Box 68760.

Division or Vital Records, P.O.

death.

the Hospital

I Yes 2 ₺No 9 Unknown 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

23b. Was decedent pregnant in the past 12 months?

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 □Ectopic pregnancy 9□Unknown

5 Other (specify)

Month

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a Date of Injury (Month, Day Year) 5 ☐ Pending investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 28c. Injury at Work?

2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 😰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

24a. Was an

26. Place of Death (Check only one)

autopsy perform 1 Yes 2 No

29b. Signature and title of certifier

31. Date filed (Month, Day,

and manner stated

ause of death (Item 23a) (Type, Print)

30. Name and address of prirson who complet Jarboe, Hollywood, MD Dr. James

Year)

NOV 0 5

State Registrar

32. Redistrar's Signature

goarde)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Alvin Wilson Wheaton November 2007 2:16 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 515 Evans Street Perryville Cecil FEITYVIII

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Ye
Oct. 24, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1957 1**x** M 2 ☐ F 212-72-3693 50 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f ahow the Medical Examinar must be notified at 1 X Yes 2 ☐ No Director Maryland Cecil Perryville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 515 Evans Street 21903 U.S.A. within 72 hours after deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cecil County Government Elementary/Secondary (0-12) College (1-4or 5+) Road Crew Il Hygiene. Twelve Years Crew Leader Elkton, Maryland filled permit. Peges 1 end 2 should be file Depertment of Heelth and Mental Hy Important: If tem 27 I a marked ofth any Injury or other traumatic avant, QDGS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Alvin Wilson Wheaton, Sr. Kathryn Eva Sherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine D. Wheaton (wife) 515 Evans Street, Perryville, Maryland 21903 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 I Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/02/07 West Chester, Pennsylvania R.A. Ferris & Co., Inc. 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** 00 an con disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Il-transit the death certificate be executed physicien ar Due to (or as a consequence of): Box 68760 cal Physician/Med as IF FEMALE: 950 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? ō Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? έ Division of Vital Records, 1X Yes 2 No 3 Probably 4 Unknown paga 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? this certificate 2000 1 Yes 28 No 1 Tyes After this certification, funeral director, Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ₺ Residence 6 ☐ Other (Specify) ဥ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending Injury 5 Pending deeth. М 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after deeth To the Funeral Director; 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò Hospital pelli 29a. Certifier 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the c 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title q D0035653 1112107 co pe o death (Item 23a) (Type, Print) 30. Name and address of person Martha Hosford, M.D., 111 West High Street, Suite 104, Elkton, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08481 State of Maryland / Department of Health and Mental Hygiene Jason Creston Ward 1- For State Certificate of Death Rea. No. Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day November 1, 2007 Medical Examiner Jason Creston Ward 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Worcester Snow Hill 209 South Morris Street If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Foreign Country) Months Days Hours Director 06/19/1978 1 X M 29 Yrs 228-43-8427 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 28a-f show Snow Hill 'natural", or items 23a or 28a-f shov Examiner must be notified at once. Worcester Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 209 South Morris St. 21863 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: Yes 2 X No specify: White If Yes, Give Year Divorced Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) nt of Health and Mental Hygiene.

It item 27 is marked other than other traumatic event, the Medical 21215-0036 Cook Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Linda Donaldson Be Creston Rogers Ward 19a. Informant's Name/Relationship (Type, Print) Linda Ward / Mother 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Burial 2 X Cremation 3 Removal from State crematory or other place) Anatomy Gifts Registry 11/2/07 Important: injury or of Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service Licenses 108 William St., Berlin, MD 21811 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart art i. Enter the disease, or compli Physician failure. List only one cause on each line 'Medical a. Asphyxia by hanging Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED the attending physician ed for use as the burial -UNPENDED The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t be detache o þ σ. Completed s been si 24a. Was an Records, autopsy performed? has ✓ Yes 2 certificate 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Other₄ Hospital: Nursing Home 5 ER/Outpatient 3 Inpatient this 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: After 1 27. Manner of Death 28b. Time of Injury Subject hanged self FOUND: Natural Yes 2 V No Division Pending Director: the 0720 hrs Nov 1, 2007 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by Could not be 3 V Suicide determined (Specify) Single Family Homicide

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 South Morris St., Snow Hill, MD 21863 20c. Location - City or Town, State Glen Burnie, MD The Burbage Funeral Home Approximate Interval Between Onset and Death 23d. Date of delivery Year Day 23e. Did tobacco use contribute to the cause of death? Yes 2 ✓ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗸 Yes Hospital or Attending Physician: Residence 6 V Other: Scene 28f. Location (Street and Number or Rural Route Number, City or Town, State) 209 south morris street, snow hill, MD 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 2, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 BA 2 Assistant Medical Examiner Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) State OCME 2007 NOV 0 6 Registrar **ORIGINAL** DHMH 17 Rev 1/2001 OCMF 2006

0730 hrs

10d. Inside City Limits

Yes 2 X No

		•	For State Registrar	State of Ma	-	epartment of F Certificate of		Reg.		01176
	Physici		Decedent's Name (First, Middle, Lass SOON BOK YC					2. Date of Death	2007 Year	3. Time of Death
	/Medio Examir		4a. Fecility Name (If not institution, give RANDOLPH HILL		HOME		SPRING		4c. County of Dea MONTGO	
	Funeral Director		210 30 11-2	ex	(In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye FEB 15,	9. Bi 1915 S	rthplace (State or Foreign country) KOREA
	Maryland I-f show	tor	Usual Residence of Decedent 10a. State	MERY	10c. City, Town o					10d. Inside City Limits 1 □X es 2 □ No
	th with the 23e or 28s ust be not	al Director	10e. Street and Number 4011 RANDOLPH	RD		10f. Zip Code 2090	2		. Citizen of What C	
920	d within 72 hours after death with the Maryland jiene. Ir than "neturel", or Items 23e or 28e-f show I'ne Macical Executational be reciffed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: A	ite, etc.
215-0	within 72 ho ene. than "netu	Completed	15. Decedent's Ed (Specify only highest gra Efementary/Secondary (0-12)	de completed) College (1-4or 5-	-) (C	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire	during most of worki		b. Kind of Busines	
Maryland 21215-0036	d be file ental Hyg ced othe c event,	To Be Cor	12 17. Father's Name (First, Middle, Last, SUK JUN KO	4	TE	CACHER	18. Mother's Name	e (First, Middle, Mai HEUNG		TION
	nd 2 shallth and 27 is m		19a. Informant's Name/Relationship (GRACE Y LEE	Турв, Print) / DAUGHT:		Maifing Address (Street	and Number or Rura			
Baltimore,	permit, Pages 1 a Department of Hes Important: If item any injury or othe		20a. Method of Disposition 1 Burial 2 Termation 3 4 Donation 5 Other (Specif	(1)	cemetery,	isposition (Name of crematory or other plate) POLITAN 22. Name and Addre	^{сө)} 11–6–(07 A	c. Location - City of LEXANDR NDS FUN	
B	99 E # 9		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused one cause on each line	the death. Do not	12303 KA t enter the mode of dyin	YAK DR U	PPER MA or respiratory arrest	RLBORO	MD 20772 Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	consequence of)		ITH DEME VERE	NTIA		MANY YEAR:
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	reconsequence of) YELITIS	1 m				MANY YEAR
68760,	tificate be executed ig physician and as the burial-transit	edical Exa	resulting in death) Last	V	consequence of) ARTHR	:				MANY YEAR
.O. Box 68	The law requires that the death certifics the has been signed by the attending phage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of the control	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of d Month	lelivery Day Year
٥	quires that n signed by ald be deta	by	Part II. Other significant conditions	ontributing to death bu	t not resulting in t	he underlying cause giv	ven in Part I.			to the cause of death? Probably 4 Unknown
Records,	The law require rate has been si page 2 should b	Completed						24a. Was an autopsy performe	prior to	
Vital	Physicien: The this certificate ral director, pag	BeC	25. Was case referred to medical examiner?	Hospital:		04	hor	h (Check only one)		
of	ding Phys h. After this funeral din	tion; To	1 ☐ Yes 2 ☑No 27. Manner of Death ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y 28b. Tin	ne of 28c. Inju	4 Nursing Ho	ome 5 🗌 Residence 28d. Describe how		becify)
Division	of or Attending after death. I Director: After d in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e Osa Place of Inju	ry - At home, farm . (Specify)	n, street, factory, office		28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
	To the Hospitel or Al within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier Check only one) Certifying Pl	nysician: To the best on miner: On the basis of and manner sta	examination and/	death occurred at the ti or investigation, in my	ime, date and place, opinion, death occur	and due to the cau red at the time, date	se(s) and manner e and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	Ce	2	29c. Licen D0 0	se number		d. Date signed (Mo	nth, Day, Year)
2	(2)	D	30. Name and address of person who			ype, Print) A AVE SIL	VER SPRI	NG MD	20906	
	Sta Regist	ate rar	YOUNG K LEE A 31. Date filed (Month, Day, Year) NOV 0 5 2007	32. Registra	r's Signature	•				

			1 - For State Registrar	State of N	Marylan			nt of H <i>te of L</i>		Mental H	lygien Reg. N	200	7	371	93
	Physic	ian	1. Decedent's Name (First, Middle, L.	ast)						2. Date of Month	Death Da	av `	Year	3. Time of	
	Physici /Medi		CHARLES E. ZEMAN							ОСТОВ	ER 2	28, 2	2007	2:	19 ^A ™
P	Examir	ner	4a. Facility Name (If not institution, gi	ve street and numbe	r)		4b. Cit	, Town, or	Location of Dea	ath	40	c. County of	Death		
			ANNE ARUNDEL MED 5. Social Security Number 6.			last birthday)		NAPOL er 1 Year	IS If Under 24 Hi	's. 8. Date of		ANNE A			
	Funeral Director		201–20–6581	1 X M 2□ F	77 (iii yis.	**	Month		Hours Mi		Day, Year)	Count		roreign
			Usual Residence of Decedent				L	<u> </u>		DECEMBE	K 24,	1323	PIANI	LAND	
	rylan		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10	d. Inside Cit	•
	ith the Marylar or 28e-1 ehow	cto	MARYLAND ANNE AF	UNDEL	ANI	NAPOLI	S							1 🗆 Yes	2. No
	vith th	Director	10e. Street and Number				10f. 2	ip Code			10g. C	itizen of Wh	nat Count	ry?	
	8 238		852 INVERRARY COU		4 Francis II	5 101		21401		(O		TED S			
	iter de	Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married	12. Was Deceder Armed Forces 1 Yes 2	?	.5.	f Yes, sp	ecify Cuba	n, Mexican, Pue	(Specify Yes or erto Rican, etc.)	No-	14. Race Black,	White, e		
936	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates			1 🗆 Yes	2 📉 No	Specify:			Specify:	WHITI	Ξ	
21215-0036	within 72 hours after death with the Maryland ane. than "neturel", or items 23a or 28e-1 ehow the Madical Examinar must be notified at	Completed	15. Decedent's E	ducation		16a. Dece				- din -	16b. l	Cind of Busi	iness/Indi	ustry	
21	thin 7	npie	(Specify only highest gi	College (1-4o	r 5+)	lite.	DO NOT	use retired	luring most of w)	orking					
21	filed wi Hygien ther th	Con		4		CHEMI	CAL	ENGIN				RMACE		AL	
Maryland	S E D S	Be	17. Father's Name (First, Middle, Las							ame (First, Midd)		
2	should ind Men imarke umatic	70	CHARLES E. ZEMAN			401 11 11		/5		ES E. P					
Z	nd 2 si alth an 27 is r r treur	1	19a. Informant's Name/Relationship MARY LOUISE ZEMAI				-			Rural Route Nur	-				
	1 and 2 Health tem 27		20a. Method of Disposition	N/WIFE	20b. P	face of Dispo	sition (N	ame of		ANNAPOL Date	20c I	ocation - C			
2	802=5		1 Burial 2 Cremation 3 4 Donation 5 Other (Special		• MOŜ	T°HOLY	ROS	ARY		EMBER 3					т.
Baltimore,			21. Signature of Funeral Service Lice		CEM	ETERY 22	. Name i	and Addres		2007 TLLOWS				RYLAN D NEW	
B	permit. Departr Importe eny inje		VUILL ES	much	M00672					ELLOWS RAL CAR ANNAPO					
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause	ed the death							TICHTL		Approximate Interval Bety)
	Pnysician	x 70	Immediate Cause (Final disease or condition			OTDOGT	C							Onset and D	Death
	/Medical		resulting in death)	aMETABO Due to (or a			5						10	HRS	30 MII
	Examiner		Sequentially list conditions	LIVER	FAILU	RE, HE	PATI	C CAN	CER					5 YE	ARS
	₽ #	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequ	uence of):									
	and and -trans	Examine	that initiated events resulting in death) Last	c. CARCIA			E								
8760,	ate be executed hysicien and the burial-transit			Due to (or a	s a consequ	dence or):									
	the the	dicai	•	d										-	
9 x c	death certific e attending p id for use as	Physician/Me	IF FEMALE:	23c. If yes, outcom	e of pregna	ncy						23d. Date	of doliver	,	
Вох	@ @ ·	ciar	23b. Was decedent pregnant in the past 12 months?	1⊡Live birth 4⊡Pregnant :			Ectopic	pregnancy				Monti		•	'ear
0	at the de by the tached	hys	9 Unknown	9□ Unknown			,	. ,,							
S, P	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions	contributing to death	but not resu	ulting in the ur	nderlying	cause give	n in Part I.	23e. Di	d tobacco	use contrib	ute to the	cause of de	eath?
ď	w require been sig should b		DSYPHEA, ASCITES							15	Yes 2	!□ No 3	☐ Proba	bly 4 □U	nknown
of Vital Record	as b	Completed								24a. W		24b. We	ere autop	sy findings a	available
<u>m</u>	The law ete has b page 2 sl	E O								pe 1□ Yes	topsy rformed? 2 X N	de	ath?	pletion of ca 2□ No	luse or
ita	ilcian: certific rector,	Be (25. Was case referred to medical examiner?						26. Place of De	eath / Check onl					
<u>></u>	Physician: this certific ral director,	2	1 ☐ Yes 2 ☐XNo	Hospital: 1 Alnpat		ER/Outpatien	t 3 🗆 🗅		4 Nursing	Home 5 ☐ Re	sidence	6 Other	(Specify)		
		.uo	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury		28c, Injury Work		28d. Describ	e how inju	ary occurred	i i		
sio	ten deat tor:	cat	2 Accident investigation 3 Suicide 6 Could not be				М		res 2 □ No						
	i Diago	Certification:	4 Homicide determined	286. Place of Ir	njury - At no atc. <i>(Specify</i>		et, facto	ry, office		28f. Location City or 1	(Street a Town, Stat		or Rural	Route Numl	oer,
	spital ours erei filled		29a. Certifier 1/X Certifying Pl	nysician: To the bes	t of my know	wladna daath	00000000	t at the tim	o data and play	a and due to th) and —an		4	
	4 4 1 9 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	edicai	(Check only 2 Medical Example)	miner: On the basis and manner s	of examinat	ion and/or inv	estigatio	n, in my op	inion, death oc	curred at the tim	e, date an	d place, an	d due to t	the cause(s)	,
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				25	c. License	number		29d. Da	ate signed ((Month, D	ay, Year)	
)			16			-		D390	137		വവ	OBER	28	2007	
	0		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)	ילכם			501	JULK	20,	2007	
1	30			ELL, MD 2	001 M	EDICAL	PAR	KWAY,	ANNAPO	LIS MAR	YLAND	2140	1		
	Sta		31. Date filed (Month, Day, Year)	32. Pojisi	trar's Signat	Jr. A	/ .	, .							
	Registr	ar	NOV 0 1	(UU/ 🎏 🍕	w.	Dr JA	254								

			1 - For State Registrar	State of M	aryland		artmen rtificat					giene Reg. No.	/ 11 11	7	37194
	Physici /Medi		1. Decedent's Name (First, Middle, I	ZACOVIC							2. Date of De Month NOVEMI		′1 2ď°	å ^r 7	3. Time of Death 10:33 aM
	Examir		4a. Facility Name (If not institution, g 31 North Bluf	f Rd.			Che	sape	Location o	Cit			County of C	1	
	Funeral Director		5. Social Security Number 6 176-03-1562 Usual Residence of Decedent	.Sex 7. A(1 ☐ M 2 🖾 F	ge (In yrs. Ia 90	ast birthday) Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da Aug 1	Year)	9. 917 F	Coun	ace (State or Foreign try) nsylvania
	e Marylanda-febow	ctor	MD Ceci	1		Town or Lo		City						10	od. Inside City Limits 1 ☐ Yes 2X No
	ath with the 23a or 28 uht be no	ral Director	10e. Street and Number 31 North Bluf	f Rd.			10f. Zip	Code 1915				_	zen of Wha	t Coun	try?
980	within 72 hours after death with the Maryland ane. than "naturel", or Items 23e or 28e-1 ehow ie Medical Examiner munt be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ ™ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1	?		Was Dece f Yes, spe 1 ☐ Yes			gin? (Spe i, Puerto I	cify Yes or No Rican, etc.)	-	14. Race - A Black, V Specify:	Vhite, e	
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "naturel", or Items 23s or 28s-f show of other than "naturel", or Items 23s or 28s-f show event, the Mudical Examiner must be notified as	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 1 2		5+)		dent's Usua kind of wo DO NOT us nema]	rk done d se retired)	tion uring mos	t of worki	ng		nd of Busine		lustry
/land	should be file and Mental Hy marked othe umatic event.	To Be C	17. Father's Name (First, Middle, La Jesse Graft	st)							(First, Middle, Hough		Sumame)		
, Mar	ges 1 and 2 should t of Health and Men If Item 27 Is marke or other traumatic		19a. Informant's Name/Relationship Joyce Peters	(Type, Print) (daughte		123 8	Sasa	Way		udo	n, TN.		r Town, Stai 7774	te, Zip	Code)
timore	permit. Pages 1 Department of H Important: If Itel eny Injury or oth		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	city)	^a		ohen	ther place 'S C	em.	11/	9/07	Ear		lle	, MD.
Bai	Depar Impor eny In		21. Signature of Fune all Services De 23a Parts. Enter the disease, or co	3/1	10051								epher MD	n I	Schaech 1635
8760,	Physician wad physician and physician and physician and physician and the priting it the priting it.	dical Examiner	Shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or a)	a conseque	Eyu, L ence of): ence of).		lu	7	CA.	a a	1651,			Approximate Interval Between Onset and Death
P.O. Box 6	s that the death certific ned by the attending p e detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pr Other (sp						23d. Date of Month		ry Day Year
rds, P.	The faw requires that the ste has been signed by th bage 2 should be detache	by	Part II. Other significant conditions	contributing to death b	out not resul	Iting in the ur	nderlying c	ause give	n in Part I.			obacco u res 2[e to the	e cause of death?
Division of Vital Records,		Completed									24a. Was autop perfo 1 Yes		24b. Were prior death	to com	osy findings available of cause of
₹	Physicien: rthis certificatal director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 🗆 F	R/Outpatien	t 3 DC	Othe			Check only one 5 A Resid	- 10	COther /	Coop to	1
ion of	inding Phy ath. ir: After thi		27. Manner of Death 1. Natural 5 Pending 2 Accident investigati	28a. Date of Inju (Month, Da		28b. Time of Injury		8c. Injury Work		2	8d. Describe			эрөспу	,
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of Inj	ury - At hon c. (Specify)	ne, farm, stre	eet, factory	r, office		2	8f. Location (S City or Tox			r Rural	Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	one) 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	f examination	vledge, death on and/or inv	occurred estigation	at the time in my opi	e, date and inion, deat	d place, a	and due to the	cause(s) date and	and manne place, and	r as sta due to	ated. the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	p Q	2			License		(e signed (M		Day, Year)
7	5:		30. Name and address of person wh				Print)		56 40					}	A 90 /.
	Sta Registr		Paul Katz, D 31. Date filed (Month, Day, Year) NOV 5 20	🎉. Registr				. ce	CIIC	.011,	MD. 2	191	3		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Velva Aline ZIMMERMAN Vovembe 1012 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 👿 F Months Days Hours Min. 81 216-22-9564 Director Oct. 12,1926 Virginia Usual Residence of Decedent 10c. City. Town or Location 10a. State 10h. County 10d. Inside City Limits show r 28a-f sh notified 1 ☐ Yes 2 No Director Maryland Allegany Little Orleans the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n 33404 National Pike NE 21766 U.S.A. by Funeral ral", or items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 21X No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filled within 72 hours after onent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural"; or iten ury or other traumatic event, the Medical Examiner 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. white Specify: 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) homemaker her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wayne Gerard Hughes 2 Flora Ellen Yager 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha F. Seal - sister 13223 Draper Road, Clear Spring, Maryland 21722 Department of Healt Important: If Item 2: any Injury or other once. Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Lawn 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State November Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AUNHIMIA SECONDAM Physician CARDIO OULMONNAY BRUEST disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner HYPOLIENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Primary CANCER UNKROUN and burial-trai Due to (or as a consequence of) Box 68760, physician Physician/Medical DEPRESSION the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🛣 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown ate has been si page 2 should | 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1∐ Yes 2 □ No 2DVNo 1 ☐ Yes Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 1 ☐ Yes 2 ☑ No 1 🗍 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 4 🗆 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

DHMH 17 Rev 1/2001

State Registrar AGTNA

MT.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1190

32. Registrar's Signature

Gloward

31. Date filed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4:20 p Sheila Angela Alexander Nov 15, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Center for Hospice Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Min. 1 □ M 2 □ F Director Dec 21, 1954 Maryland 218-60-5259 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County r 28a-f shov notified at 1 □Xes 2 □ No Director **Baltimore** N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or U.S.A 21215 2503 Violet Avenue - #905 r than "natural", or items 23a the Medical Examiner must I Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ Nyo Specify. Specify Black þ 3 □ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Mediconce. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Nursing Home** Nursing Assistant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth N. Parson Frank Alexander ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2414 Hollinsferry Road Baltimore, Maryland 21230 Delores Brooks Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Byurial 2 ☐ Cremation 3 ☐Removal from State Lansdowne, Maryland 11/23/07 4 ☐ Donation 5 Other (Specify) Mt. Zion Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Enter the disease, or complications that caused the deshoc and ailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) week **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine requires that the death certificate be executed that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for (Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ pe 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performed? /es 2 No certificate I 1∐ Yes **Division or Vital** 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☐ Yes 2**2 N**o 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Hospital or Attending n 24 hours after death.

te Funeral Director: Af

within 2 To the

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

and manner stated.

29c. License number 1)25205

29d. Date signed (Month, Day, Year) November 15, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
(1). A. R. Lay C. BMC 6701 N. Charles St. Balte. in 1 2120 >

32. Registrar's Signature

30246

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month tawin MES DOWN 2:15 PM M 200 /Medical 4a. Fecility Name (If not institution, give street and number)

5 Pleasant Pides Examiner 4b. City, Town, or Location of Death 4c. County of Death Pleasant Ridge Drive Owings Mills Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth Month Day Year) 08/31/1938 **Funeral** Birthplace (Stete or Foreign Country) Days 213-36-3357 Months Hours TECM 2 F MD Director Yrs Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location me 23a or 28a-f show 10d. Inside City Limits MD Baltimore Be Completed by Funeral Director Owings Mills 1 Yes 2 No death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Pleasant Ridge Drive 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1-EXYes 2 □ No If Yes, Give Year or Dates: or iteme Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Munical Examiner Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "na any injury or other traumatic event, Ite Mexit 2006. Independent Elementary/Secondary (0-12) College (1-4or 5+) Janitor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Edwin Brown Sr. Beatrice Willis 19a. Informant's Name/Relationship (Type, Print) Hattie Brown/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Pleasant Ridge Drive Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov 19 1 ☐ Burial 2 ☐ Semation 3 ☐ Removal from State Chesapeake Crematory Inc. 2007 Beltsville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Eremation and Früheral Alternatives M01443 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 DEctopic pregnancy ŏ Month 4 Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 3 Probably 4 Unknown 1 Nes 2 No page 2 sl 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending after death. investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 0 29d. Date signed (Month, Dev. Year) Physician 30 Name and address of person who Landmark Drive, Suite 129, Glen Burnie, MD 21061 , M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 I Registrar

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			Decedent's Name (First, Middle, Last)					2. Date of Dea	th	· · · · · · · · · · · · · · · · · · ·	3. Time of Death
	Physici /Medio		Timothy J. Beach	:				1 1-12-2	2007	Year	1:45 A M
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	Funeral Director			M 2□F 50	Yrs.	Months Days	Hours Min.	(Month, Day 10-22-1	Year)	Coun Mary	try)
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P.O. Box 68760, Division or Vital Records,

be executed burial-transit nding physician the as for signed by t d be detach page 2 s certificate Physician: funeral director, After this or Attending within 24 hours after death.

To the Funeral Director: At completely filled in by the fu

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Pages 1 and 2 should be

Maryland 21215-0036

Baltimore,

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.B. CLEBUE

(Check only one)

29b. Signature and title of certifier

DO438.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) Miember 19, 2007

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31. Date filed (Month, Day, Year) 32. Registrar's Signature GORALI NOV Sal Guel

			1 - For State Registrar	State of Ma	ryland		rtment of F				giene 2	007	37200
۴			Decedent's Name (First, Middle, La	st)						2. Date of De	ath		3. Time of Death
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ú	Director		238-36-93 1 3	I□M 2 X F	77	Yrs.	Months Days	Hours	Min.	Jan 16	1930	Nort	h Carolina
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Loc	ation						10d. Inside City Limits
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	or 28	Director	10e. Street and Number				10f. Zip Code				•	of What Cou	untry?
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Balt	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Lice Thomas Gregor	1800		Ma 30	Name and Address CNabb Fu 1 Freder	ss of Fac inera	T ^{ty} Hom Road	e, P.A.	ville.	Marv1	and 21228
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	with To I	Σ	29b. Signature and title of certifier	40			29c. License		730		29d. Date sig	ned (Month,	Dây, Year)
	5		30. Name and address of person who	MD 656	9 N.	CHI					F, 40	1 21	208
	Sta Registra	- 1	31. Date filed (Month, Day, Year) NOV 2 1	2007 32. Remiserar	s Signature	K A	barte						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER 19. 2007 4:09 A DAVID LEE BEDSAUL /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1**∑**M 2□F Hours Director Aug. 19, 1958 Maryland 218-78-1607 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show at ns 23a or 28a-f sh must be notified 1 Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 223 Crocker Drive 21014 USA Apt. B 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced White permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. **7 is marked other than** "r Elementary/Secondary (0-12) College (1-4or 5+) Bus Contractor Public School 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Dean Gilbert Bedsaul Jr. Patricia Ann Dayhoof 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Bedsaul / Mother 208 Schucks Road, Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Grove Baptist Cem. 11-26-07 | Bel Air, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner COTONARY al Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) BedSawl David Lee MOODES Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral directors. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Piace of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 040363

Registrar
DHMH 17 Rev 1/2001

10

State

Chesapeake Dr. Bel Air, MD 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

timente

2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 11:55 AM ESTELLE BULETTE 18,200 DORIS Vovenher /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs.

Months Days Hours 1 ace Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2€F Yrs. 215-28-2409 1931 Maryland Director 14, Usual Residence of Decedent r 28a-f show notified at 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2€ No Director Maryland | Harford Aberdeen 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? items 23a or be 1202 Montreal Drive 21001 USA "natural", or items 23a Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo f Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: ģ White 3 Widowed 4 Divorced Completed the Medical E 16a, Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed w f Health and Mental Hygier tem 27 is marked other th other traumatic event, the 12 U.S. Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Elizabeth Nickle Frank Henry Wood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau once. Cindy McLeod / Daughter 4687 Newington Road, Jefferson, MD 21755 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Memorial Grdn 11-27-07 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdo

23a. Parti. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Immediate Cause (Final disease or condition resulting in death) vena Physician Chymil /Medical Due to (or as a consequence of): Examiner Wallomy o pathy if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner arrem burial-trar Due to (or as a consequence of) pertension Physician/Medical the attending p for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diahetes 1 TYes 2 ☐ No 3 Probably 4 ☐ Inknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No director, page 2 autopsy perform 1 Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation in 24 hours after usus the Funeral Director. A malately filled in by the fr 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one)

certificate be executed Box 68760, P.O. Records. Vital ō Division

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Physician: To the Hospital or Attending within 24 hours after death. the 0

> State Registrar

31. Date filed (Month, Day, Year) 2007

29b. Signature and title of certifier

5 uni 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of I	Maryland	-	artment of rtificate c			lental Hygie Reg	ene 1. No. 2	107	37203
Ē	Physicia		1. Decedent's Name (First, Middle, La		izabetl	h Baq	lev			2. Date of Death Month	Day OV 15, 20	Year 007	3. Time of Death 7:05 p M
Ÿ.	/Medic Examin		4a. Facility Name (If not institution, given				4b. City, Tow	, or Locatio	n of Death		4c. County	of Death	
				7726 Spence				1 1/11-4		imore			Arundel
	Funeral Director			Sex 7. 1 □ M 2 □ y F	Age (In yrs. I	(ast birthday) O1	If Under 1 Ye Months Da		ler 24 Hrs. s Min.	8. Date of Birth (Month, Day,) Aug 12		9. Birthp Coun	place (State or Foreign ntry) Virginia
	put N		Usual Residence of Decedent 10a, State 10b. County		10c. City	y, Town or Lo	ocation					1	0d. Inside City Limits
	Aaryla F sho ed at	ō		ne Arundel				Glen B	urnie				1 □ ¥ es 2 □ No
	the 128a-	rec	10e. Street and Number				10f. Zip Coo	e		109	g. Citizen of	What Cour	ntry?
	h with 23a or st be	alD	7726 Spencer Road					2	21060			U.S	.A.
	ems a	Funeral Director	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.	S. 13.	Was Decedent If Yes, specify (of Hispanic (Suban, Mexic	Origin? (Specan, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ck, White,	
သူ	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	by Fu	1 □ Never Married 2 □ Married 3 □ Waidowed 4 □ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date	^		1 ☐ Yes 2 ☐	№ Speci	ify:		Specif	y:	Black
5-0036	hour sal Ex		15. Decedent's E			16a. Dece	dent's Usual Oc	cupation			l 6b. Kind of B	usiness/In-	dustry
<u>ლ</u>	hin 72 9. In "na Medic	Completed	(Specify only highest gr Elementary/Secondary (0-12)	rade completed) College (1-4	or 5+)	(Give life.	kind of work do DO NOT use re			ing		Own	Home
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yland	be file d oth event	Be	17. Father's Name (First, Middle, Las	es Maddox				18. Mo	ther's Name	e (First, Middle, Ma Sara	aiden Surnai ah Mad		
	hould d Mer narke natic	ဠ	19a. Informant's Name/Relationship			19h Maili	na Address (Str	eet and Nur	mber or Run	al Route Number,			Code)
Mar	nd 2 s lith an 27 Is r traur		Wallacia Malone Dau				•			Burnie, Maryl	-		,
	s 1 ar if Hea item 2		20a. Method of Disposition			Place of Dispo emetery, cre	osition (Name o	place)	: 1	Date 2	0c. Location	- City or To	own, State
Ë	Page nent c int: If		1 ☐ BK rial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec		ate		ley Family		y	11/21/07	K	enbridg	e, Virginia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.		21. Signature of Funeral Service Lice	ens / C	L	2	2. Name and Ad	en Broth	ers Fun	eral Service, Baltimore, Mo	P. A.		
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cau	used the death	h. Do not en	ter the mode of	dying, such	as cardiac	or respiratory arres	st,		Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	. (0	100	Can	CLR						Onset and Death 3 Mon Hy
ja s	/Medical Examiner		resulting in death)	Due to (o	r as a conseq	uence of):							
	Lxaiiiiiei	<u>.</u>	Sequentially list conditions,	b. — Due to (or	r as a conseq	uence of):						-	
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (0	ao a conceq								
o,	execu in and ial-tra	Еха	resulting in death) Last	Due to (o	r as a conseq	uence of):							
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Box	death certifi e attending I d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		ome pr pregna th 2 □ Feta nt at time of d	aldeath 3	□Ectopic pregn					ate of deliv Ionth	very Day Year
	0 0	ysic	1 ☐ Yes 2 🗫 No 9 ☐ Unknown	9☐Unknov		leaui 5		/					
ت. ص	w requires that the di been signed by the should be detached	by Ph	Part II. Other significant conditions	contributing to dea	th but not res	ulting in the u	underlying caus	given in Pa	art I.	23e. Did tob	acco use cor	ntribute to t	the cause of death?
rds	equires en sig auld be		Ity per tens	ion						1 ☐ Ye	s 21000	3 ☐ Pro	bably 4 Unknown
ဝ္ပ	law re as bee 2 sho	Completed	Hypothy	ruidism						24a. Was an		prior to co	opsy findings available ompletion of cause of
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Vital Records,	ding Physician: The lav n. After this certificate has funeral director, page 2.	Be	25. Was case referred to medical examiner?	Hospital:	_			Other:		th Check onl one			
0	Phys this a	<u>۲</u>	1 Yes 2 No 27. Manner of Death	1 ☐ In		ER/Outpatie	ent 3 DOA	4∟	Nursing Ho	ome 5 Resider 28d. Describe hor			fy)
o	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month	, Day Year)	Injury	М	Injury at Work? 1 ∐ Yes 2	2 □ No				
Division or	- Attender death rector:	Certification:	3 Suicide 6 Could not 4 Homicide determine	a 200. Flace C	of injury - At he g, etc. (Specia	ı ome, farm, si fy)	treet, factory, of	ice		28f. Location (Str. City or Town	eet and Num State)	ber or Rui	ral Route Number,
Ō	urs after or ral Di						th oor	a tie				200000	stated
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier 1	Physician: To the base aminer: On the base and manne	sis of examina	owledge, dea ation and/or i	nvestigation, in	my opinion,	e and place death occu	, and due to the ca rred at the time, da	ate and place	anner as: , and due	to the cause(s)
	To the To To To To To To To To To To To To To	Me	29b. Signature and title of certifier	1.	n			ense numb	- 1	29	d. Date sign	ed (Month	, Day, Year)
	1		Luzeni ()h	mes /	lano	n 10	10 00	0036	24'	2	11/10	107	
(8		30. Name and address of person wh	7100	of death (Iter	m 23a) (Type	Print)		ح ،	1207.101	00 IA	M)	カ・ハマイ
	C	nt a	31. Date filed (Month, Day, Year)		gistrar's Sign	1) YCK(Lex C	auce	4,20	1gzWAC	ec,11	11).	01021
	Sta Regist		NOV 2 1	2007	Hockore 2	13	Brank)			V			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:15a Deborah A. Breece Nov 14, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examine N/A **Baltimore** 2525 Maisel Street if Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 □ M Maryland Director May 15, 1956 218-82-3458 51 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.
marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ia or 28a-f show t be notified at 1 ☐Xes 2 ☐ No Director Baltimore N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A 21225 2525 Maisel Street must Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Examiner 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Black 3 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Never Worked Elementary/Secondary (0-12) College (1-4or 5+) Disabled traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F Be 1 and 2 should be Mary Breece John Ashby ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:s Department of Health ar Important: If item 27 Is any Injury or other trau 2525 Maisel Street Baltimore, Maryland 21225 Mary B. Aye Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 20a. Method of Disposition 1 ☐ Murial 2 ☐ Cremation 3 Removal from State 11/19/07 Brooklyn Park, Md Cedar Hill Cemetery & Mausoleum 5 Other (Specify) 4 Denation 22. Name and Address of Facility 21. Si nature i Funeral Service Lice see Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NAMBN /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, from the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-transi and Due to (or as a consequence of) Box 68760. physician Physician/Medical the SS attending IF FEMALE for use . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregns 3 Ectopic pregnancy Month Year in the past 12 mon 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown signed by to d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes page 2 should Completed been . Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has autopsy performe 2 Physician: 25. Was case referred to medica examiner? funeral director, 26. Place of Death (Check only one Be Other: 4 Nursing Home Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Desidence 6 ☐Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending | 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Registrar DHMH 17 Rev 1/2001

State

To the Hospital within 24 hours a To the Funeral D

29a. Certifier

29b. Signati

Nam

31. Date filed (Mo

2 Medical Examiner:

and manner stated.

t 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 6:20 AM M Theodore Crabill Collins November 16, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carriage Hill Nursing Home - Bethesda Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 № M 2 🗆 F 70 Director 578-48-1375 11/10/1937 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7510 Old Chester Rd. 20817-United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 MaYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Dept. of Energy Elementary/Secondary (0-12) College (1-4or 5+) Program Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Collins Herma Reineke ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James G. Gray, Jr./Executor 7510 Old Chester Rd. Bethesda, MD 20817-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any Injury or o
once. 1 ☐ Burial 2 KI Cremation 3 ☐ Removal from State 11/20/2007 Beltsville, Maryland Chesapeake Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signature of Funeral Service Licensee M00382 Figler & Loleman Silver Spring, Maryland 20910-933 Gist Ave. 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ № 0 24a Was an autopsy performed? Yes 221No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760, within 24 hours at Hospital

Baltimore, Maryland 21215-0036

ax1

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

and manner stated

Medical Center Dn

1 👺 certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 🗹 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRucha- Bao MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 8:45 AM November 13, Benjamin Carpenter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4708 Dorset Ave Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 10/12/1941 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days PA Country) 1 X M 2 □ F 66 Director 040-34-9338 Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show ns 23a or 28a-f shormust be notified at 1 ☐ Yes 2 No Director CT Middlesex Middletown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 06457-876 Newfield St Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after de nent of Health and Mental hygiene. and the the sant if item 27 is marked other than "natural", or item ury or other traumatic event, the Medical Examinear. Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Government Elementary/Secondary (0-12) College (1-4or 5+) Waste Disposal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gertrude Clift Lansing T Carpenter 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy Freeman/Sister 4708 Dorset Ave. Chevy Chase, MD 20815-20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages I Department of I Important: If Ite any Injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Chesapeake Crematory 11/20/2007 Beltsville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sen m00382 22 Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910ohm ann 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Renal Carcinoma Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter of identifying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical has been signed by the attending pages 2 should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 214 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page certificate 1 ☐ Yes or Attending Physician: funeral director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner 2 No Sisters Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes r 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 ☑ Natural 28b. Time of 28a. Date of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending within 24 hours after death.

To the Funeral Infector: All completely filled in by the fu investigation 1 □ Yes 2 □ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francine A. Higgs-Shipman MD Rockville NO 20850 1355 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

NOV 2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #7&8 Per FH G873 11/28/07ermicate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Chat terton 3 Dan 2001 /Medical NOW 6 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 19932) University of Maryland 5. Social Security Number 6. Sex ledical Cente 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 76 11.02.1921 Director 212.30.5615 ΜĎ Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 No 2 No MD Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with U.S.A. 22-30 Athol Avenue unknown Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2ENo þ Specify: Specify: White 3 Widowed 4 □ Divorced "natural", Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Leroy Brown Mary Marvie Sherbert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4502 Bonds Place, Pomfret, MD 20675 David Chatterton/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crem. 11.20.07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation And Funeral Balto M01443 Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 pe Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 DNo
9 Unknown Day Year P.O. I signed by the a ld be detached for 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown been sl Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 24□No 24a. Was an has e 2 autopsy page performe certificate 2 000 or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 1 Dpatient ို 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident 5 Pending investigation (Month, Day Year) Injury death. 1 ☐ Yes 2 ☐ No To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital hours 1 🔀 DertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

В

within 24

Registrar

30. Name and address of person who completed cause of death-(ftem 23a) (Type, Print)

29b. Signature and title of certifier

Jafna

31. Date filed (Month, Day, Year)



29c. License number

7436

Greene St.

29d. Date signed (Month, Day, Year)

2007

DHMH 17 Rev 1/2001

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State Registrar

Maryland 21215-0036

NGTA

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20Sta Baltimore, N

Division or Vital Records, P.O. Box 68760,

Franklin Square Drive, Boltimore, MD. 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Elizabeth 31. Date filed (Month, Day, Year) JSKI 9000 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ant's Name (First, Middle, Last) **Physician** -2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ong Green Nursing TIMOFE HOME If I Inde Birthplace (State or Foreign Country) 1 Year Social Security Number 6. Sex last birthday) 7. Age **Funeral** Months 1 M 2 XF 219-22-8027 Director Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Tes 2 No Director More 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify. 2 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) econdary (0-12) College (1-4or 5+) 18 Mother's Name (First Middle Maiden Surnami 17. Father's Name (First, Middle, Last) 2 should be fi and Mental H Be permit. Pages 1 and 2 sh. Department of Health and Important: if Item 27 is ma any Injury or con-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) aine 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee M01363 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of type shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHUROSCLEROTIC CARDYOVASCULAR Physician DISEASE YEARS /Medical Due to (or as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi Box 687666 and Due to (or as a consequence of) physician Physician/Medical the as attending for use a IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) P.0. ed by the a detached f 9 Unknown 9 DUnknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown 1 TYes Completed 24a. Was an autopsy performed? 1∐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident Injury 5 Pending To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No death. investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 131136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9005 KILBRIDE RD, BATTIMORE, UM 21236 WALLACE WI)

32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Arthur Collins 11 2007 8:45a. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2009 Woodlawn Dr. Apt. F Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0.4 10. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1**⋈** M 2□ F 240-36-9284 74 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 U.S.A. 2009 Woodlawn Drive Apt Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: Black 3 Widowed Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Liquor Truck Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Truck Driver na Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Corena Collins Vernon Hester 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 339 East Lorraine Ave, Baltimore, Md 21218 Tamara Payne-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 11/26/07 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F. H. West 4300 Wabash Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Diffuse arheroscierosis Due to (or as a consequence of): abets mellits Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

Physician /Medical Examiner

certificate be executed

P.O. Box 68760,

Records,

or Vital

Division

To the Hospital or Attending Physician;

Physician

/Medical

Examiner

Director

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Completed

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Funeral

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r than "natural" or Items 23a or 28a-f show the Medical Examiner must be notified at

I Hygiene.

permit. Pages 1 and 2 should be filed wo Department of Health and Mental Hygien Important; If them 27 is marked other than any injury or other trainmant.

within 72 hours after death

Baltimore, Maryland 21215-0036

sician and burial-trans attending physician for use as the buria as has certificate this c within 24 hours after users...

To the Funeral Director: After this

Physician/Medical

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 20 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work?

Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Medical

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

ted cause of death (Item 23a) (Type, Print)

N. Greene St. Baltimore, MO 2120 32. Registrar's Signature

State Registrar

Angus James Capel NOTOMERER P 14, 2007 7:55 Frundral Director Fundral Director Fu			1- State of Maryland / Department of Health State Registrar Amend 10e&19b, perFH, g873, 11/27/07 Spertificate of Death 1. Decedent's Name (First, Middle, Last)	th 2. Da	Reg. No	2007	37211
## County of Death ## County of	_			NQ	PEMBER"	14, 2001	7 7:50F M
218-18-2153 12 M 21F 84 Vrs. Morths Days Hours Mrs. Odd-crits Odd-cr			4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number)	ion of Death		c. County of Death	
Top State Top To			218-18-2153 X 2 F 84 Yrs. Months Days Hour	irs Min. (M	fonth, Day, Year) Cou	place (State or Foreign intry) SC
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24a. Was an autopsy finding prior to completion of death? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 5 Pending investigation 28a. Date of Injury 28b. Time of Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 28a. Date of Injury 28b. Time of Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28d. Describe how injury occurred	requir een si ould b	ted			1 ☐ Yes 2	No 3□ Pro	bably 4 □Unknowr
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(aballo, my) D25886 Nov. 14-200			COUCOS, 119		No	0.14-	200+
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LILIA CEBALLOS M. D. 760 OSLER DRIVE, TOWSON, MARYLAND 21204	1			nwson v	MARVI AL	VID Ston	4.
State State NOV 2. 1 2007 32. Registrar's Signature	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	merenductive s	A TO VELLE	That has als line \$6.5	7

9. Birthplace (State or Foreign 10d. Inside, City Limits 1 Yes 2 No 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. 16b. Kind of Business/Industry 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chicago 20c. Location - City or Town, State Elwood, chicago Homes P. MO 21216 Balton Approximate Interval Between Onset and Death hours 23d. Date of delivery Day Month 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred train Cullision VS 281. Location (Street and Number or Ryral Route Number, City or Town, State) North Howard Street at West Mulberry Street, Buttmore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Datersigned (Month. Dav. Year) 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Simnon Greca 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar ORIGINAL

Year

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND TIEM/20a c. perFH, 0873, 11/28/07, WS
State of Maryland Department of Health and Mental Hygiene Reg. No. U U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Cleo Betty Dent 8:08 PM M 9, November 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Securify Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 7 F 80 579-34-4296 Director 10/16/1927 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show be notified 1 ☐ Yes 2 No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 1400 Fenwick Lane 20910itеms 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify: Completed by 3 ₩ Widowed 4 Divorced Black "natural", er than "natur the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 27 Is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Anderson Mamie Burns 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Lancaster/Grand Daughter 11811 Avon Way #1 Los Angeles, CA 90066item 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 26, +₩Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Beltsville, MD 21. Signature of Funeral Service Lip 22. Name and Address of Facility
Rapp Funeral & Cremation Services 1400382 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co Examine The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): P.O. Box 68760. ng physician as the burial Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth in the past 12 months? 3 ☐ Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a

To the Funeral I

completely filled erlifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 20 NIP 7610 CARPOLLETVE KANG 32. Registrar's Signature State Germa D Registra

07-08898	
Amanda Dear	ing

nanda Dearing	4 5	State of Maryland / Department of Certificate of	Health and Mental Hygiene Death Reg. No. 2007 3721
Physician	Rec	nistrar Decedent's Name (First, Middle,Last)	2. Date of Death 3. Time of Death
Mical Examine	r	Amanda Jo Dearing	b. City, Town, or Location of Death November 17, 2007 4c. County of Death
711	4a	Facility Name (if not institution, give street and number) 4 University Hospital	Baltimore
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
Director		219-94-8487 1 M 2 XF 28 Yrs.	Months Days Hours Min. 11/1/1979 Coonday MD
Á		sual Residence of Decedent la. State 10b. County 10c. City, Town or Locati	on 10d. Inside City Limits
d how any	-	MD Ba	altimore 1 X Yes 2 No
72 hours after death with the Maryland n"matural", or items 23a or 28a-f show al Examiner must be notified at once.	10	De. Street and Number 3834 Brooklyn Avenue	10f. Zip Code 10g. Citizen of What Country? 21225 USA
th the N	- L	La Wa	s Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
ath wit		Married Armed Forces? X Never Married 2 Married Armed Forces?	es, specify Cuban, Mexican, Puerto Rican, etc.) White
ifter de	٠ اح	Widowed 4 Divorced If Yes, Give Year	Yes 2 X No specify: Specify: It's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
5-0036 seed within 72 hours at Aggine and other than "natural other than "natural other than "natural other than "natural other than "natural other than "natural other than "natural other than "natural other than "natural" other than "natur		during m	lost of working life. DO NOT use retired)
136 hin 72 e. than "	Completed	12	Unemployed
21215-0036 ould be filed within 72 I Mental Hygiene, s, marked other than "		7. Father's Name (First, Middle, Last) Charles Tivis Dearing Sr.	18.Mother's Name (First, Middle, Maiden Surname) Barbara Ellen Walker
2121 Mental Markec event,	9 1 0 1	On Informatic Name/Relationship (Type Print)	g Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
D de Si ta	/11	Barbara E. Dearing / Mother 383	4 Brooklyn Avenue, Baltimore, MD 21225 sition (Name of cemetery, Date 20c. Location - City or Town, State
re, MC s 1 and 2 s f Health at If item 27	2	crematory or o	Silion (Hame or cometer);
D age if it is		4 Donation 5 Other Specify:	CI Children of Facility
Baltir permit. I Departme Importatinjury or	2	21. Signature of baneral Selvine Licensee	Charles I Stevens Fineral Home Inc.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	
'edical		Immediate Cause (Final disease a. <u>Acquired Immune Deficien</u>	cy Syndrame (AIDS) with complications
		or condition resulting in death) Due to (or as a consequence of): b.	
200		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
-	E١	Cisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
ords, P.O. Box 68760, w requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial - transit		d.	/ 02_ DTT 27 29_6ME = 97/_ 12/13/07 TT
o, e be ex ysician burial	ledical	X UNPENDED X #FNDED #1, perME, g874, 12/5/07 IF FEMALE: 23c. If yes, outcome of pregnancy	TT / 23a, PII, 27, 28a-f, perME, g874, 12/13/07 TT 23d. Date of delivery
68760, certificate be nding physic ise as the burner	an/N	23b. Was decedent pregnant in the 1 Live birth 2	Fetal death 3 Ectopic pregnancy Month Day Year
Box 68760 e death certificate b the attending physi ed for use as the bu	Physician/Me	1 Yes 2 No 9 V Unknown g Unknown	Other (Specify)
O. But the d		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 V No 3 Probably 4 Unknown
s, P.O. irres that the first that the signed by do be detac	ed by	Narcotic use	24a. Was an 24b. Were autopsy findings available
cords law requas been	Completed		autopsy performed? 1 Yes 2 No 1 Yes 2 No
tal Rec	S		26.Place of Death (Check only one)
of Vital Records, ng Physician: The law requir Miler this certificate has been s meral director, page 2 should	Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/Outpatient	
n of V ling Phy After th	5	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time	No. 1
ion ttendin death.	atio	1 Natural 5 Pending Investigation Fnd 11/17/2007 FNd 6 28e. Place of Injury - At home, farm, s	treet factory office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Division tall or Attendid its after death.	Certification:	Suicide b X Could not be (Specify)	or Town, State)
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Function After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u		4 Homicide	courred at the time, date and place, and due to the cause(s) and manner as stated.
o the lathin 2 to the longlet	edical	one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.	igation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)
F S F S	ğ	29b. Signature and title of certifier	O.C.M.E. November 18, 2007
		30. Name and address of person who completed cause of death (Item 23a)	
		Margarita Korell MD. Assistant Medical Examiner 11	1 Penn Street, Baltimore, MD 21201
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Energy ?

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) NOVEMBER 15, 2007 **Physician** DOROTHY FRANCES DRISCOLL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1 □ M 2 🗙 F Feb. 18, 1919 Pennsylvania Director 213-16-9283 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Forest Hill Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21050 USA 2B200 Kimary Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify. Completed by 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Artist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Sarah Watson Adam Albert Kleiber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2B, Forest Hill, MD 21050 <u> Shirley Torbit / Sister</u> 200 Kimary Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State permit. Page Department o Important: If any Injury or Garrison Forest VA Cem. 11-21-07 | Owings Mills, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Foneral Service Acceptage

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Rd., Abingdon

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear vallyre. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of): 1317 Cokesbury Rd., Abingdon, MD 21009 Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and -tran physician ar s the burial-to Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hası autopsy page performed? 1 ☐ Yes 2 No 2 No certificate 25. Was case referred to medical 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Certification: 1 Natural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: Aft

completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

this

or Attending

the Hospital

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

the death certificate be executed

Box 68760,

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Division or Vital Records,

State Registrar

615 W. MACPHAIL ROAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21014 BEL AIR, MD.

29d. Date signed (Month, Day, Year)

November 16 2007

29c. License number

032275

31. Date filed (Month, Day, Year)

DAVID DUNN

**

NOV 2

29b. Signature and title of certifier

32. Registrar's Signature 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** November 14, 2007 7:24 PM Edward Thomas Dickson Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 1504 Southview Road Bel Air 8. Date of Birth (Month, Day, Year)
Dec. 8, 1931 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 11XM 2□ F Yrs. Director 75 New Jersev 144-22-7378 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23s or 28s-f show the Medical Exeminer must be notified at 1 Yes 2 No Directo Marvland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1504 Southview Road 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Specify 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Corrugated Service 12 Owner / Operator traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 Edward Thomas Dickson Sr. Alva Rebecca Howe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trau Cynthia Rae Yost / Daughter 754 Ridge Rd., Fawn Grove, PA 17321 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hilltop Service Corp. Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 11-16-07 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): 68760, physician Physician/Medical the use as the attending Box IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ğ in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5

cate has been signated to page 2 should to Completed certificate has funeral director, Be ဥ After this Certification:

Old son.

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

24a. Was an

3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of

autopsy performed? Yes 2 No 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

1 Natural 2 Accident 5 Pending investigation 6 Could not be determined 3 🗌 Suicide 4 T Homicide

28a. Date of Injury (Month, Day Year) 28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29a. Certifier

29c. License number

29d. Date signed (Month, Dey, Year)

Craig M. Show skness D 00370 78

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. SHAUCH NESSY M.D.

32 Abgistrar's Signature 104 PLUMTREE Rd. STELLS BELAIR, MD 31. Date filed (Month, Day, Year)

2007



DHMH 17 Rev 1/2001

Division of Vital

Hospitel or Attanding Physicien:

death

the

filled in by

cal

State Registrar

within 24 hours after death To the Funeral Director:

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** ennis 12 2807 vovember /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** altimore JOSeph 5. Social Security Number 1ch N a If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex Age (In yrs. last birthday) **Funeral** 1 M 2 ☐ F Min -502 ar Director and Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1 Yes 2 No Director Maryland more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code eans Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: be filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: a 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other transmit any injury or other traumatic event and once. Elementary/Secondary (0-12) College (1-4or 5+) anag CI 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ennis ပ 19a, Informant's Name/Relationship (Type. Print) (Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ames 110 omet Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 12007 Dundalk, 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility 21. Signature of Funeral Service Licensee Balton MD 21216 Approximate Interval Between Onset and Death 23a. Part1 Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ymphoma /Medical r as a consequence of): ficiency syndrome Examiner eass Sequentially list on differe, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an ate has autopsy perform 2 1∐ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Inter (Specify) 2 No 1 TYes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p

Dennis

150 MD 31. Date filed (Month, Day, Year) State

29b. Signature and tifle of certifier

29c. License number

29d. Date signed (Month, Day, Year) 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-838 Baltimore MD NEUTaw 32. Registrar's Signature

NOV 2

Registrar

Director

Be Completed by Funeral

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Physician

/Medical

Examiner

Funeral

Director

	Please 1					. Ensure A		-	_	ible.		
For State		State of Ma			ment of F <i>licate of</i>	Health and N <i>Death</i>	vienta	al Hygier . _{Reg.}		07	07	010
Registrar 1. Decedent's Name	e (First, Middle, Last,)						ate of Death	20	111	3. Time	of Death O
Dolore		ry	Doe	lle				_{onth} vember	Day 19	Year 200	79:0	0A M
	f not institution, give). City, Town, o	or Location of Death			4c. Count		/	
-	GOLTON D					STON			TA	LBO		
5. Social Security N 218-36		x 7. Ag □ M 2□X	e (In yrs. last birth 66 Y		Under 1 Year onths Days		8. Da	ate of Birth fonth Day 9	² 4 ⁰ 1	9. Birth	place (State	or Foreign D
Usual Residence of 10a. State MD	Decedent 10b. County N/A		10c. City, Town	or Location		LANDTOWN					10d. Inside	City Limits
10e. Street and Nur 7834 W	mber YNBROOK	ROAD	I	1	10f. Zip Code 21	1224		10g.	Citizen of	f What Co		
11. Marital Status 1 □ Never Marr 3 Ⅸ Widowed	ied 2 Married 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		If Ye	s Decedent of les, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yoo Rican,	es or No- , etc.)		ack, White	ncan Indian, e, etc. HITE	
(Spec	15. Decedent's Edu	ication	1	(Give kind	t's Usual Occu	during most of work	kina	16t	b. Kind of I	Business/	Industry	
Elementary/Seco		College (1-4or §		life. DO	LERICA	∍d)	<i>g</i>		C)FFI	CE	
17. Father's Name FRANK	(First, Middle, Last)	ZYMANSK	I			18. Mother's Nam STELL			den Surna RON)			
	ame/Relationship (7)		I .	-		et and Number or Ru COVE CI			ity or Town		Zip Code) MD	21219
	position Cremation 3 II 5 Other (Specify)		1	y, cremato	on (Name of ory or other pla EMATO	t	Date - 23 -			-	Town, State	MD
21. Signature of Fu	uneral Service Licens	see 👤		22. Na		ress of Facility CV ESACO AV		I/ROSE ROSE				HOME 237
23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	on	a.	d the death. Do n ne.	Pa	he mode of dy		c or resp				Approxin Interval I Onset ar	Between nd Death
Sequentially list contains, leading to in cause. Enter Unde Cause (Disease or that initiated event resulting in death)	erlying r injury s	c	a consequence of									
·		d	1					A				
IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 26 9 ☐ Unknown	nt pregnant 2 months? ☑No	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal death		ctopic pregnan ther <i>(specify)</i>	су				Date of de Month	livery Day	Year
Part II. Other sign i	ificant conditions co	ontributing to death t	out not resulting in	the unde	orlying cause g	iven in Part I.	2	23e. Did tobac	cco use co		o the cause robably 4	
								24a. Was an autopsy performe	d?	prior to death?	utopsy findin completion	gs available of cause of
25. Was case refe	erred to medical					26. Place of Dea	-	1□ Yes 2€	→No	1 L Yes	s 2₽No	
examiner?		Hospital: 1 ☐ Inpati	ent 2 ER/Out	Inatient	3□ DOA O	ther: 4 Nursing H		_	ം ഒത്	other (Spe	ecify) Day	nh-tork k
27. Manner of Dea		28a. Date of Inj (Month, Da	ury 28b. T	Time of njury	28c. Inj	4 LI Nursing P		Describe how		·	H	CUSE S
2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of in	jury - At home, fai tc. (Specify)	rm, street			28f. L	_ocation_(<i>Stree</i> City or Town, :	et and Nu State)	mber or A	ural Route N	lumber,

Examiner Physician/Medical cate has been signed by the a page 2 should be detached by Medical Certification: To Be Completed by funeral director,

certificate

After this

within 24 hours after death.

To the Funeral Director: /
completely filled in by the f

(Check only one)

29a. Certifier

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

BALTIMERE, Md

clan use of death (Item 23a) (Type, Print)

and manner stated.

BUNL

MILYARK URIEL 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

NOV 2

30. Name and address of person who completed ca

32. Re ORIGINAL

DHMH 17 Rev 1/2001

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Yea NOVEMBER 20, 2007 **Physician** 1:40 A ENDSLEY MARY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 09-23-1924 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 🔀 83 Pennsylvania Director 217-22-5286 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No New Windsor Maryland Carroll Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1306 Woodland Circle 21776 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Seward Brown Edna Mae Scanlin ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2107 Harford Rd Fallston, MD 21047 Jim Roberts (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 11-21-2007 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licenses 610 W. MacPhail Rd Bel Air, MD 21014 Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** responde /Medical resulting in death) Due to (or as a consequence Examiner rezum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and A the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If ves. outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown icate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a, Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? director, Be (26. Place of Death Check onl one Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined filled in by 4 Homicide M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hou

To the Fune

completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

615 W. MACPHAIL ROAD 32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEL AIR, MD.

035526

29c. License number

21014

29d. Date signed (Month, Day, Year)

november 20 2007

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician November 11, 2007 9:20a Mary Kathryn Engel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Laurel Regional Hospital Laurel Prince Georges if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗓 F 214-48-6928 60 Director January 5, 1947 California Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2**√**☐ No must be notified Maryland Howard Laurel Directo 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 9280 Livery Lane Apt. A 20723 USA 2**3**a Funeral ural", or items 2 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 2**X** No Yes, Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 💆 No Baltimore, Maryland 21215-0036 White Specify. ιτ Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 'natural" er than "natur the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) US Govt. Secretary 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN ည Wetmore Audrey Heimel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Joseph Engel- Husband 9280 Livery Lane, Apt. A, Laurel, Maryland 20723 27 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition FI 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 11/14/2007 Alexandria, Virginia 21. Signature of Funeral Strvice Licensee 22. Name and Address of Facility Fleck Funeral Home, INC. 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause followers or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9□Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Ovarian Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2**X** No 2 🗌 No certific 25. Was case referred to medical 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 X ER/Outpatient 3 DOA ၉ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

8

within 24 hours a

Medical

29a. Certifier

(Check only one)

31. Date filed (Month)

29b. Signature and title of certifier

Thomas H. Burguieres, MD

Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Registrar

DHMH 17 Rev 1/2001

State

1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D22966

Laurel Regional Hospital, ER Dept., 7300 Van Dusen Rd, Laurel,MD 20707

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Lillian Anna Engel November 17,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner 4c. County of Death TIMOK PITAL n/a If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Days Hours Director 215-01-7358 88 09/09/1919 Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene. • marked other than "natural", or Items 23a or 28a-f ehrow 10c. City, Town or Location 10b. County 10d. Inside City Limit 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 31 Enjay Avenue 21228 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 White 1 ☐ Yes 201No Specify: 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Iljury or other traumatic event once. Be William A. Hoofnagle Edna Mae Brogan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert A. Engel / Son 31 Enjay Avenue Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore National Cem. 11/20/07 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, MD 21. Signature of Funeral Service Licensee Market. 21229 e or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the dis as shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** acute myocard, a /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed: After this certificate Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 □ DOA Division or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Agre 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 2 1

DHMH 17 Rev 1/2001

Physician /Medical Examiner Division or Vital Records, P.O. Box 68760,

burial-transit attending physician for use as the burial signed by the aid be detached for Hospital or Attending Physician: funeral director, this After t וח 24 hours after death. the Funeral Director: Aft within 24 To the F

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examina-

3altimore, Maryland 21215-0036

1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

N. Chonles

58303

November 18 2007

4 State

Regulatrat

Medical

31. Date filed (Month, Day, Year)

CAMINES 6701 32. Registrar's Signature

m

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11-17-2007 10:15 P M Margaret M. Froehlich /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 03-24-1947 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 📉 F 60 Yrs 123-36-3885 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show a or 28a-f shot be notified a 1 ☐ Yes 2 No Directo Maryland Wicomico Delmar 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 800 E. Chestnut St. Apt 704 21875 an "natural", or items 23a Medical Examiner must b U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Froehlich Mary Schimkus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) George Froehlich (Brother) 903 Fitzpatrick Drive Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 11-21-2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or deriving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year 5 ☐ Other (specify) I □ Yes 2 No 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 TYes 2 □ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 K No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE ၀ 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Funeral I 29a. Certifier Medical (Check only one) Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physician: State

Division or Vital Records, P.O. Box 68760

with the Maryland

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

DR. TARIQ MAHMOOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

29c_License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month

Physician /Medical Examiner

1 - For State Registrar

burial-transit and Box 68760, attending physician as the use Por P.0. ed by the a detached f signed by t has Physician:

Beatrice Lenora Foote 15, 2007 9:00& Nov. 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Future Care/ Charles Village Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 21 F 220-22-2310 92 Director May 11, 1915 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the M. dical Examiner must be notified at N/A 1 Yes 2 □ No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 829 N. Chapel Gate Lane 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 be filed with Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important: If them 27 is marked other the any injury or other trainmant. 10th grade Private Industry Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John H. Allen Blanche H. Chase ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 Niece 607 E. 30th Street Baltimore, Maryland Ruth Maria Allen-Tolson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 11/21/07 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus, Maryland Arbutus Memorial Park 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final **Physician** disease or condition resulting in death) /Medicai Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed' After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: or Attending (Month, Day Year) 1 Natural Injury 5 ☐ Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: the 1 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PHYSICIAN 57543 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. BALTIMORE ST. BALTIMURE MO 21223 SANDHU 1940 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 1 2007 Registrar

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				1 - For State Registrar	State of Maryland		tment of Health a ificate of Death		0007	07005
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		th the or 28a e noti	Director	10e. Street and Number	<u> </u>	BCT IL	10f. Zip Code		10g. Citizen of What Co	ountry?
		s 23a	ral	505 S. Giles Str			21014		USA	siana kadisa
a.n		ter de item	Funeral	11. Marital Status 1 □ Never Married 2X Married	12. Was Decedent Ever in U.S Armed Forces? 1⊠Yes 2 □ No	S. 13. W	as Decedent of Hispanic Oric Yes, specify Cuban, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)	- 14. Race - Ame Black, Whit	
	036	ours af	þ	3 ☐ Widowed 4 ☐ Divorced	1 ⊠ Yes 2 □ No If Yes, Give Year or Dates:	1 [☐ Yes 2[X] No Specify:		Specify:	Vhite
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19	Maryland	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)	1	Address (Street and Numbe			Zip Code)
ER		Healt Healt tem 2		Jack Franetovich 20a. Method of Disposition	20b. P	lace of Disposi	cGregor Way, I	Bel Air, MC	21014 20c. Location - City or	Town, State
EME	altimore,	Pages ient of nt: if i		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State 1		atory or other place) emorial Gdn	11-24-07	Bel Air, N	Maryland
NOVEMBER	alti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at once.		21. Sunature of Funeral Service Licer	see	22	Nume and Address of Facility	Home. P.A		
	8	7 O E # 9	1	23a. Part). Enter the disease, or com	marron	1 51) West Broadwa	ay, Bel Air	, MD 21014	Approximate
		Dhuaisian) N	shock, or heart failure) List only	one cause on each line.	not enter	the mode of dying, such as	cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
		Physician /Medical		disease or condition resulting in death)	a. PROSTATE CAN Due to (or as a consequ					
		Examiner		Sequentially list conditions	b					
		ed sit	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a consequ	uence of):				
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IO	0	O 0	Physician/Medical	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of de 9□Unknown	eatn 5∐1	Other (specify)			
FLORIO	s, P.	requires that the sen signed by the		Part II. Other significant conditions of	ontributing to death but not resu	ulting in the und	lerlying cause given in Part I.	23e. Did t	obacco use contribute t	o the cause of death?
1=1	ord	w require been sig should b	Completed by					11	Yes 2 No 3 P	robably 4 X Unknown
CH	Record	2 0 10	nplet					24a. Was	an 24b. Were a	utopsy findings available completion of cause of
071	al F	n: The ficate har, r, page		22.11				1□ Yes		s 2 No
MET	Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	Other	of Death (Check only o	one) dence 6 X Other (Spe	HOSPICE
FRANETOVICH	٦Ô٢	ng Phy ter thi neral o	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		how injury occurred	icity/ HOBI TOE
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	Division or	or Att after de Direct in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, stree	et, factory, office	28f. Location (City or To	Street and Number or F wn, State)	ural Route Number,
	-	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2			ysiclan: To the best of my know					
		the Ho hin 24 h the Fu mpletely	Medical	one)	niner: On the basis of examination and manner stated.	tion and/or inve		th occurred at the time,	date and place, and du	e to the cause(s)
ā		To t To t	Σ	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mon	, ,,

State Registrar DR. TARIQ MAHMOOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

2300 DULANEY VALLEY RD.

32. Registrar's Signature

29c. License number

D 43727

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician LIVIA 2007 NOV /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A LOSPITAL BATIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🕱 F Maryland Apr 30, 1947 218-44-6995 60 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No Baltimore N/A 7 is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examiner must be notified Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21230 2409 Ridgely Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Black Specify þ 3 XVidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. important: If them 27 is marked other transmatt event any injury or other traumatic event and once. **Baltimore City Schools** College (1-4or 5+) Elementary/Secondary (0-12) Teacher 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy M. Robertson William Robertson မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2409 Ridgely Street Baltimore, Maryland 21230 Travis B. Fleet 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 11/20/07 Arbutus Memorial Park 4 Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Lic 22 Name and Address of Facility Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 21217 23a. Part f. Enter the disease, or complications that caused the shock, or heart failure. List only one cause at each line death. Approximate Interval Between Do not enter the mode of dying, such as cardiac or respiratory arrest Onset and Death Immediate Cause (Final disease or condition resulting in death) CUT Physician E /Medical Due to (or as a consequence of): Examiner HABDOMY Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed 7 E physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death use 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by UASCULAR 3 ☐ Probably 4 ☐ Onknown 1 ☐ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 ☐ Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Impatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident

Division or Vital Records, or Attending Physician: within 24 hours after death.

To the Funeral Director: / Hospitai

investigation 6 Could not be determined

30. Name and address of person who completed cause of death (Item \$3a) (Type, Print)

OST

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year)

SOPH

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

NOV 2 1 2007 egistrar's Signature

To the

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician November 15, 2007 Eleanor Fanelli 6:30AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🛛 F Yrs. 99 May 17, 1908 Director 058-10-2167 New York Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a•f show notified at show 1▼ Yes 2 No Directo Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 2 r must be n 1504 Columbia Avenue 20850 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: ?7 is marked other than "natural", or Items traumatic event, the Medical Examiner mo Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Ite 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes 2 No <u>م</u> Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Alberico Pescatore Filomena Forino 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie N. Marotta/ Daughter 1504 Columbia Avenue, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t of November 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2007 Parklawn Memorial Park 19, Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signature of Funeral Service Licenses Rockville; Inc. 300 West Montgomery Avenue M00335 23a. Part1. Enter the disease, or a milications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 3 Years disease or condition resulting in death) Metastatic Breast Cancer (Right) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. physician the use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Thrombocytopenia 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Mitral Valve Stenosis 24a. Was an page 2 s autopsy performe Aortic Stenosis 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Tes 2 No funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 X Natural ours after death.
neral Director: Ai 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D0019785 November 15, 2007

State Registrar 1201 Seven Locks Road, #202, Rockville, Maryland 20854

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. egistrar's Signature

Frauke Westphal,

31. Date filed (Month

	1 - State Registrar	-	artment of Health and Metrificate of Death	Reg.	0007	37228
Physician /Medical	1. Decedent's Name (First, Middle, Last) John Leo Furnkas	•		11 1		3. Time of Death 4:05 A M
Examiner Funeral	4a. Facility Name (If not institution, give str Stella Maris Hospic 5. Social Security Number 6. Sex	,	4b. City, Town, or Location of Death **Baltimore** If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		4c. County of Death Baltimore 9. Birth Cou	place (State or Foreign
Director te pai	218-34-1518	10c. City, Town or Lo		4-18-1918		10d. Inside City Limits 1 □Yes 2√□No
r items 23a or 28a-f sl iner must be notified Funeral Director	10e. Street and Number 3908 Schroeder Ave.	relly hall	10f. Zip Code 21128	10g.	Citizen of What Cou	intry?
sal", or items 2 examiner mus by Funera		Armed Forces? 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerton 1 □ Yes 2√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√	pecify Yes or No- p Rican, etc.)	14. Race - Ameri Black, White Specify: Whi	, etc.
ygiene. her than "natura t, the Medical E t, completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	Completed) (Give life.	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) Ceen Florist	king	orist	ndustry
d Mental Hyg narked other natic event, i	17. Father's Name (First, Middle, Last) Joseph R. Furnkas 19a. Informant's Name/Relationship (Type				<u> </u>	in Code)
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Mary Furnkas (Wife) 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Rei 4 □ Donation 5 □ Other (Specify)	3908 20b. Place of Disponsion Commencery, cree	Schroeder Ave. Pe sition (Name of matory or other place)	rry Hall,		
Departm Importa any Inju once.	21. Signature of Funeral Service Licensee	197	2. Name and Address of Facility Sch 705 Belair Rd Nott	Ingham, M	0 21236	es, Inc.
physician and the burial-transit the burial-transit dical Examiner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jisease of in jury that initiated events resulting in death) Last d.	SEPSIS Due to (or as a consequence of): Due to (or as a consequence of):	let tite mode or dying, social as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
igned by the attending physical be detached for use as the by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv	very Day Year
should be deta should be deta leted by Ph	Part II. Other significant conditions control	ibuting to death but not resulting in the u	inderlying cause given in Part I.		co use contribute to	
ertificate has been sector, page 2 should	25. Was case referred to medical examiner?		26. Place of Dea	24a. Was an autopsy performed 1 Yes 2 X	prior to co	opsy findings available ompletion of cause of
After this ouneral dire	1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	spital: 1 Inpatient 2 ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Place of Injury - At home, farm, st building, etc. (Specify)	of 28c. Injury at Work? M 1 Yes 2 No	ome 5 Residence 28d. Describe how in 28f. Location (Stree City or Town, S	njury occurred t and Number or Rui	
within 24 hours after death. To the Funeral Director: / completely filled in by the f Medical Certificati	29a. Certifier 17 Certifying Physic (Check only one) 2 Medical Examina	clan: To the best of my knowledge, dea er: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place ovestigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the company of the	29b. Signature and title of certifier 30. Name and address of person who com	inleted cause of death (Itam 23a) /Tuno	29c. License number D 477 2,7		Date signed (Month	
State	DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)	2300 DULANEY VALLI 32. Registrar's Signature	EY RD. TIMONIUM,	MD 21093		

DHMH 17 Rev 1/2001

Registrar

NOV 2 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	arylan						ental Hy	giene)			
			State Registrar			Cei	rtificat	e of E	Death			Reg. No	200	7_	3723	30
6	Physicia	an	Decedent's Name (First, Middle, Las Florence								2. Date of Dea	_	9, 200°	5	3. Time of Dea 6:30	ath TDM
	/Medic	al .	4a. Facility Name (If not institution, give)		4h City	Town, or	Location		Novembe		County of D		0:30	Ľ
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,	Funeral		Social Security Number 6. S	7. A		last birthday)		1 Year Days		24 Hrs. Min.	8. Date of Birt	h	9.1	Birthpla	ice (State or Fo	reign
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)	the rotif	Director	10e. Street and Number	ЕГУ		ROC	10f. Zip					10g. Cit	izen of What	Count	y?	
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	ems ;	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.	.S. 13.	Was Dece	dent of His	spanic Oi n, Mexica	rigin? (Spe	cify Yes or No Rican, etc.)	-	14. Race - A Black, W			
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21215-0036	hour tural	ed b	15. Decedent's Ed	Year or Dates: ucation		16a. Dece	dent's Usu	al Occupa	ation			16b. K	and of Busine	ss/Ind	ustry	_
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덜	tal Hy	Be	17. Father's Name (First, Middle, Last)					Ì			(First, Middle,		Surname)			
<u> </u>	ould hard	၉	Joseph Karp								Michki					
Maryland	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (7) Dr. Michael Gold				•	,			al Route Numb				•	
	1 and Healt tem 2		20a. Method of Disposition	5011	20b. F	Place of Dispo	osition (Na	me of			Rockvil		ocation - City			
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Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.		21. Signature of Funeral Service dicen		1110											
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause one cause on each	ed the deat line.	th. Do not en	ter the mo	de of dyin	g, such a	s cardiac	or respiratory a	rrest,			Approximate Interval Betwee Onset and Deat	en th
	Physician		Immediate Cause (Final disease or condition	a. P	NE	umon	AIL								Oliset and Deal	
7	/Medical Examiner		resulting in death)	Due to (or a	s a consec	quence of):	1111	0	M) tx	à DMY	OPAT	HY				
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Вох	attenc for us	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 🗆 Feta	al death 3	⊟Ectopic p						23d. Date of Month		ry Day Yea	ır
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	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		Part II. Other significant conditions	ontributing to death	but not res	sulting in the u	underlying	cause give	en in Parl	t I.	23e. Did 1	tobacco	use contribut	e to th	e cause of deat	h?
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or'	Physi this o	ျ	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpa		ER/Outpatie			4 L r	Nursing Ho	me 5 Res			Specif) Living	5
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<u>D</u>	al or after	erti	4 ☐ Homicide determined	building,	etc. (Spec	ity)					City or To	wn, Sta	te)			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.			ysician: To the be												
	the H hin 24 the F nplete	Medical	one)	and manner				9c. Licens								
	To To cor	2	29b. Signature and title of cortifier	Na-		M.D.				660		23U. D	ate signed (A	10	7	
		1	30. Name and address	completed cause a	f death /Ita	m 23a) /Tuna	Print\						11/00	1	1	
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	Dogiet	ror	MAY 9 1	2007		P. L	FLABAB.	(A)								

DHMH 17 Rev 1/2001

Florence K.

ORIGINAL

P.O. Box 68760 Division or Vital Records,

determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

ST TONSON MO

ASCertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Herardun 29c. License number D 98303

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) NOVEMBER 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMON J. CHARLES w 6701 N. Cherles

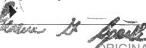
State Registrar

Medical

29a. Certifier

2007

31. Date filed (Month, Day, Year)



32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year TYRONE HARVIN, SR. 11, NOV. 2007 11:25 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GENESIS MULTICARE - TOWSON TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Months Days Hours 12XM 2 F Director 46 DEC. 16, 1960 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 XYes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 filed within 72 hours after death with Items 23a by Funeral 4108 PARKHEIGHTS AVE. 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9TH MOVER MOVING & STORAGE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES DINGLE EVOLA HARVIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ERIC BOATWRIGHT/BROTHER 2267 PENTLAND DR., PARKVILLE, MD 21234 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5500 O DONNELL ST. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/20/2007 BALTIMORE, MD 21224 BAYVIEW 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. es 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Let only one cause on each line. Immediate Cause /Final Due to (or Ba consequence of): **Physician** mmore deficiency disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to initiodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 1 ☐ Live birth 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Noningib 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2.20No 1 ☐ Yes certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 ☐No 2 Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) eral 27. Manner of Death 28c. Injury at Work? 28b. Time of After Certification: 28d. Describe how injury occurred 12 Natural 5 Pending Injury ral Director: / 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DSJ465 11/13/02 WD 30. Name ar address of person who completed cause of death (Item 23a) (Type, Print) Road Glen Burnie MD 21061 MUNESES MC 7845 31. Date filed (Month, Day, Year) NOV 2 1 State 32. Resistrar's Signature 2007 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center Funeral Director Funeral Director Funeral Director Funeral Director Funeral Director Funeral Director Funeral Director Funeral Director Anne Arun (if not institution, give street and number) Baltimore Washington Medical Center 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. S. Date of Birth (MM/DD/YYYY) S. Date of Birth (MM/DD/YYY) S. Date of Bir	ndel
4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center 5. Social Security Number 214-64-9158 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location Eldersburg 4b. City, Town, or Location of Death Glen Burnie 4c. County of Death Anne Arun 14c. County of Death Anne Arun 15. Social Security Number 214-64-9158 1 XM 2 F 38 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location	ndel
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Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Eldersburg	oreign Country) MD
Carroll Eldersburg	10d. Inside City Limits
109. Citizen of What USA 109. Street and Number 779 Irongate Circle 21784 11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1988–90 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - White, or Specify: S	1 Yes 2 Y No
779 Irongate Circle 21784 To give the property of the proper	t Country?
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1 mechanic 1 mech	
Tr. Father's Name (First, Middle, Last) Robert A. Hamilton 19a. Informant's Name/Relationship (Type, Print) Beverly Roeder 19a. Informant's Name/Relationship (Type, Print) Beverly Roeder 19a. Informant's Name/Relationship (Type, Print) Beverly Roeder 19a. Informant's Name/Relationship (Type, Print) Beverly Roeder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 19a. Informant's Name/Relationship (Type, Print) Beverly Roeder 19a. Informant's Name/Relationship (Type, Print) Beverly Roeder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 19a. Informant's Name/Relationship (Type, Print) Beverly Roeder 10b. Mailing Address (Street and Number or Rural Route Number, City or Town 19a. Informant's Name/Relationship (Type, Print) Beverly Roeder 10b. Mailing Address (Street and Number or Rural Route Number, City or Town 10c. Location - Or Crematory or other place) 11c. Father's Name (First, Middle, Last) Robert A. Hamilton 10b. Mailing Address (Street and Number or Rural Route Number, City or Town 10c. Location - Or Crematory or other place) 11c. Father's Name (First, Middle, Last) Robert A. Hamilton 10b. Mailing Address (Street and Number or Rural Route Number, City or Town 10c. Location - Or Crematory or other place) 11c. Father's Name (First, Middle, Last) 12c. Name and Address of Facility Haight Funeral Home 12c. Name and Address of Facility Haight Funeral Home 12c. Name and Address of Facility Haight Funeral Home 12c. Name and Address of Facility Haight Funeral Home 12c. Name and Address of Facility Haight Funeral Home 12c. Name and Address of Facility Haight Funeral Home 12c. Name and Address of Facility Haight Funeral Home 12c. Name and Address of Facility Haight Funeral Home 12c. Name and Address of Facility Haight Funeral Home 12c. Name and Address of Facility Haight Funeral Home 12c. Name and Address of Facility Haight Funeral Home 12c. Name and Address of Facility Haight Funeral Home 12c. Name and Address of Facili	
Beverly Roeder (mother) 779 Irongate Circle, Eldersburg, MD 200. Location - 200. Place of Disposition (Name of cemetery. Date 200. Location - 200. Place of Disposition (Name of cemetery. Date 200. Location - 200. Location	Z1 / 84 City or Town, State
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Sykesvii Burial 2 X Cremation 3 Removal from State All County Cremation 1 Burial 2 X Cremation 3 Removal from State All County Cremation 22. Name and Address of Facility Haight Funeral Home P.O. 195 Sykesviile, MD 21784	e & Chapel
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or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	
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if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	
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YO TO THE PROPERTY OF THE PROP	inbute to the cause of death?
Part II. Other significant conditions 23c. If yes, outcome of pregnancy 1	Probably 4 V Unknown
Part II. Other significant conditions contributing to death but not resulting in the state of the part	Were autopsy findings available prior to completion of cause of
24a. Was an autopsy performed? 1 ✓ Yes 2 No 26. Place of Death (Check only one)	death? 1 ✓ Yes 2 No
26.Place of Death (Check only one)	Others
examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; 4 Nursing Home 5 Residence 6	Other:
28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending FNd 11/17/2007 Fnd 10:38 am 1 Yes 2 X No unk	
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2 290. Signature and the or conting	gned (Month, Day, Year) er 18, 2007
MAL IN BLOWN MAT	
30. Name and address of person who completed cause of death (Item 23a) Mellssa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)



32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.ZUU Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ROL **Physician** DE 18:10 M 5 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City Baltimore Harbor Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2🏞F 1941 Maryland Nov 15, Director 214-38-8972 66 Usual Residence of Decedent so 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medic. Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 □ No Director Baltimore Maryland Baltimore City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21225 Funeral 1522 Church Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Wood Products Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Smith Lillian Lorrain မှ Shain Romain Woomer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5356 Walker Wood Court, Manchester, MD 21102 Martina L. Gnall - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov 20 permit. Pages 1
Department of H
Important: If Itel
any Injury or oth XXBurial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Prk. 2007 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MO 台 7250 Wash Blvd, Elkridge, Pk, Meadowridge Mem. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one y use on each line. Immediate Cause (Final a Physician disease or condition resulting in death) Due to (x a a consequence of): /Medical Examiner Sign Tally at a city if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examine and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4□Pregnant at time of death P.O. the detached 9 Unknown 9 Unknow signed by t. d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Ş 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy perform certificate Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl o e director Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P After this funeral Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Manner of Death 28c. Injury at Work? Certification: Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident e Hospital or Attendi 124 hours after death. e Funeral Director: A filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 32 Registrar's Signature 6 State

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Registrar

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			State of Maryland / Department / Department / Department / Department / Department / Department / Department / Department	artment of Health and N rtificate of Death		71111 7 3 1 2 3 1
Ŷ			Registrar 1. Decedent's Name (First, Middle, Last)	Timodic of Beatif	Reg. N 2. Date of Death	3. Time of Death
	Physici		Violet I. Home	ns	Nov 20	2007 10:00a ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Dove House	Westminster		Carroll
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
Mar.	Director		215-24-1468 Tyrs. Usual Residence of Decedent		Feb 22 1	930 Maryland
	land ow		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Many Ffsh fied	tor	MD Carroll Elders	bura		1 □ Yes 2√□ No
	or 28s	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	ath wi	ral	2031 Rudy Serra Drive	21784		US
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ▼No Specify:		Specify: White
8	tural	ed k	Α	dent's Usual Occupation	16b	Kind of Business/Industry
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nd	8 - a e	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maide	en Surname)
yla	2 should be and Mental is marked o	To	Ellwood Barnhart	Hest		ornbaker
Maryland	ss 1 and 2 should b of Health and Ment item 27 is marked r other traumatic e			ng Address (Street and Number or Run		y or Town, State, Zip Code)
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و			1 Burial 2 Cremation 3 Removal from State	matory or other place)		Location - City or Town, State
altimore,			4 Donation 5 Dother (Specify) Meadowr: 21. Signature of Functial Service Upgansee 22	idge Memor Nov	23 2007	Elkridge, MD
ä	permit. Departr Importa any inf		John A Kellner	Bu Old raba	rrier-Qu	een Funeral Home
48	the still		23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause or each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Winfield MD2178 Approximate
	Physician		Immediate Cause (Final	Darlas TAN	in	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	Man Com		11 mml
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9/80	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dical	d			
×	leath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			and Data of delline
ROX	leath atter for u	cian	in the past 12 months	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
j.	w requires that the d been signed by the should be detached	ysi	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown			
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Hecords,		Completed			24a. Was an	24b. Were autopsy findings available
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⋛	or A after of Direction by	Certification:	4 Homicide determined 28e. Place of injury · At home, farm, str	eet, factory, office	City or Town, Sta	and Number or Rural Route Number, ate)
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	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	red at the time, date a	and place, and due to the cause(s)
	withir To th	Me	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
	./		- Uslo athilling	000 69597	- 11	12/602
-	5	Ì	30 Name and address of person who completed cause of death (Item 23a) (Type,	Print)		
			1000+ L. Nice 555 South Center	r Street West	miuster it	1021157
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 1 2007	A 5	8000	
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Registrar

State

31. Date flied (Month, Day,

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32! Registrar's Signature

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nnie M. Hughes	State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Reg. No. 2007 3723
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Medical Examiner	Month Day Year
rel a	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	1122 Chesapeake Drive Havre de Grace Harford
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Days Hours Min. 2007) Foreign
Director	36-2516 1 M 2 X F 68 Yrs. Months Days Nours Aug. 11, 1939 Country) N.C.
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
8 .1	Maryland Harford Havre de Grace
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r death with th	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
	1 Yes 2 X No 3 - Widowed 4 Divorced If Yes Give Year 1 Yes 2 X No specify: Specify: White
5-0036 led within 72 hours after tygiene. other than "natural", of the Medical Examiner. Completed by F	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
6 172 ho ral Ex	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)
withir siene.	8 Baker Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
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7 5 6 2 9 O	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD d 2 sho lth and n 27 is numation	Nicole B. Wheeler / Daughter 217 Carol Avenue, Aberdeen, Maryland 21001
imore, MD 2 Pages 1 and 2 shou ment of Health and N lant: If item 27 is n or other traumatic	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Page ment chant; tant; or oth	4 Donation 5 Other Specify: Hilltop Service Corp. 11-20-07 Towson, Maryland
Baltimore, permit. Pages 1 at Department of He Important: If ite	21. Sign are of Funeral Service License 22 Name and Address of Facility Home, P.A.
Physician	1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
/Medical	failure. List only one cause on each line. Between Onset and Death Immediate Cause (Final disease a. Oxycodone intoxication
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tox 687 eath certific attending p for use as th	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (Specify)
Sox death death as atternal	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)
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VISION After de l'inceto in by t	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division os spital or Attending nours after death. neral Director: After filled in by the func Certification:	Suicide S A Could not be determined (Specify) residence or Town, State) or Town, State) 1122 Chesapeake Dr. Havre De. Grace.
To the Hos within 24 hr To the Fun completely	
To the Its within 24 To the For completed	2 9b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
2	November 12, 2007
	30. Name and address of person who completed cause of death (Item 23a)
	Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State	
Registra	NOV 2 I 2007 See 15 Agree 15 A

amend #10e Per FH G888 2/06/09 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month e.S ra Vovember 10: Inc 2007 /Medical 4c. County of Death Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner HOSPICO Care christ Center For More If Under 24 Hrs. If Under 1 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Min 1□M 2**√**F -40-458 0 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 Yes 2 No Director Mary land

10e. Street and Number 17 more 2519 10g. Citizen of What Country? hafayette Ave. 10f. Zip Code death v Funeral Was Degedent Ever in U.S. Armed Forces? Race - American Indian, . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No 1 Tyes Specify Specify: 2 3 ₩Widowed 4 □ Divorced 1ac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore marked other than Elementary/Secondary (0-12) College (1-4or 5+) injury or other traumatic event, the ducator 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be VISTEI Butle turo ပ e 19a. Informant's Name/Relationship (Type. Print) (Daugh +21) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Patricia MD 21216 23 Baltun W atayette 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Location - City or Town, State Arbutus 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 27/07 Mem. 4 □ Donation 5 □ Other (Specify) En tombinut 21. Signature of Funeral Service Licensee eval Home, 122Bh Balton MD 21216 North 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SNURE **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE Se 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Day in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknow been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a Was an certificate has autopsy Yes Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Wish U 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending | 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 58303 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) ANUN itMus in amilist Tonson MO 6701 N 31. Date filed (Month, Day /Year) 200 Registrar's Signature State Registrar

Registrar
DHMH 17 Rev 1/2001

State

malwing DR, Hestminster, MD 21157

leted cause of death (Item 23a) (Type, Print

349

32. Registrar's Signature

M. PANSURIYA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure	All Copies Are Legible.
State of Maryland / Department of Health and	Mental Hygiene
Certificate of Death	Reg. No. 2 0 7
(First, Middle, Last)	2. Date of Death

			For State of Maryl State Registrar	•	rtment of Hea tificate of De		,	giene Reg. No. 🔿 🔘	0. 20	0 7 0 1 0
Е	5.75		Decedent's Name (First, Middle, Last)				2. Date of De	ath 20	U /	3. Vime of Death
	Physicia /Medic		NAIM S ISSA				Month November		Year	10:10 AM
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	Funeral Director		296-94-5093 15 2□F 7	yrs. last birthday) 72 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 05/1	y, Year)	9. Birthp Coun Isra	
3	and w		Usual Residence of Decedent 10a. State 10b. County 10c	: City, Town or Loc	ation				1	0d. Inside City Limits
	f sho	힏	MD Anne Arundel	Glen Bur	o i o					1 ☐ Yes 2 No
-	r 28a	Director	10e. Street and Number	Gien Bui	10f. Zip Code		Т	10g. Citizen of W	hat Coun	itry?
-	23a o 23a o ist be		102 N. Crain Highway #878		21060			USA		
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene, if Health and Saraf show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☑ No		Vas Decedent of Hisp Yes, specify Cuban,		ecify Yes or No Rican, etc.)	Black	- Americ , White,	an Indian, etc.
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2.	and 2 ealth a n 27 is ner trai		Jamileh Soudah/Daughter	9014	Breezewoo	od Terra	ce #102	Greenbe	elt,	MD 20770
ָב ה	of Hei		20a. Method of Disposition	0b. Place of Dispos	sition (Name of natory or other place)	1	Date	20c. Location -	City or To	own, State
Ĕ,	Page nent d		1. ★Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		en Memoria		Nov 21 2007	Glen Bu	rnie,	Maryland
Dallillor	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee	143 0	Name and Address	nd Funera			Mar	muland 21206
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F	Physician		Immediate Cause (Final						ŀ	Onset and Death
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<u>×</u> '	death certi e attending ed for use a	ian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pr	Fetal death 3	Ectopic pregnancy			23d. Date		ery Day Year
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IVISION	ath. or: After	ation:	27. Manner of Death 1 ★ Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury	Work?	at es 2 □ No	28d. Describe	how injury occurr	ed	
ואר הוא	al or Atter al after de la Directe din by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury building, etc. (S	At home, farm, stre specify)	eet, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rura	al Route Number,
	To the Hospital or Attending Physician: Thin 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, to	edical (29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of m 2 ☐ Medical Examiner: On the basis of examon manner stated.	amination and/or inv	occurred at the time vestigation, in my opin	e, date and place, nion, death occur	and due to the red at the time	cause(s) and ma , date and place,	nner as s and due t	stated. to the cause(s)
:	To th within To th compl	Me	29b. Signature and title of certifier		29c. License r	number		29d. Date signed	(Month,	Day, Year)
			Refert & anderson!	MD	P196	50		Novembe	_ /8	2007
	7		30. Name and address of person who completed caus of death	(Item 23a) (Type,	Print)					
	6				zene Stra	t Balt	mere 1	hD 212	0/	/
H	Sta Registr		31. Date filed (Month, Day, Year) 32. Posstvar's		hart i					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 15 2007 8:35 p M Nancy Igo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Severna Park Anne Arundel If Under 1 Year If Under 24 Hrs. Months Davs Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** JULY 11 1930 Pennsylvania Months Days 77 193-24-5635 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 □Yes 2 No iral", or items 23a or 28a-f sl Examiner must be notified Director FLVolusia New Smyrna Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 160 Breeze Way Court 32169 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify Specify: White 3 Widowed 4 Divorced "natural", Completed Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Secretary Higher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kirschner Florence Barefoot Lawrence မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Keffer - daughter 1704 Saxony Place, Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory, Inc. 11/16/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore, MD Steven H. Williams 21228 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-trai resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy certificate 1□ Yes 2 1110 25. Was case referred medical examiner? Be 26. Place of Death (Check only one) Assisted Hospital: Other: 4 Nursing Home 5 Residence 6 Definer (Specify) 1 ☐ Yes 2 VNC 2 1 Inpatient 2 ER/Outpatient 3 DOA ours after death. neral Director: After this filled in by the funeral di this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I completely filled 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

10

Millerville, MI) 2/118

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and title of certifie

31. Date filed (Month, Day, Year)

evkion

29b. Signate

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Betty M. Junker NOVEMBER 2007 07:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT BALTIMORE N/A AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEP 8 1924 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F Months Days Hours 231-18-6903 83 Director Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Set. If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or Items 23a or 28a-f shoved in the second seco 1 ☐ Yes 2 No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 2402 Rockwell Avenue USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Sellers Walker Ernestine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2402 Rockwell Avenue, Catonsville, MD Gregory S. Junker - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If It any injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Mem. Park 11/20/2007 Sykesville, MD 21. Signature of Funeral Service Licensee H. Williams Name and Address of Facility
MacNabb Funeral Home, P.A.
301 Frederick Road, Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) YONTHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical attending p 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ AIRIAL FIBRILLATION 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an cate has by page 2 s autopsy perform Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 ☐ Yes 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) P21798 900 CATON AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 KHAVAN DEEP BAJAJ

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

			Please Type or Print in Bla			_
			- FOr	Department of Health and	d Mental Hy	giene
			1 = State Registrar	Certificate of Death		Reg. No. 2007 37245
	Physici /Medic		1. Dependent's Name (First, Middle, Last) Katherine Grines Jour	ner	2. Date of De Month	Day Year
	Éxamin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De		4c. County of Death
		4.	SINAL HOSPITAL OF BALTIN 5. Social Security Number 6. Sex 7. Age (In yrs. last			th 9. Birthplace (State or Foreign
	Funeral Director		216 · 36 · (226) 1 M 2XF Co7	Yrs. Months Days Hours Mi		1940 Country) MD
	nyland how at		10a. State 10b. County 10c. City, To	own or Location		10d. Inside City Limits
	he Ma 8a-f s otified	ector		lynn oak		1 ☐ Yes 2 No 10g. Citizen of What Country?
	be filed within 72 hours after death with the Maryland the Wighen. Hygiene. Adother than "natural", or items 23a or 28a-f show event, "he Meckel Examiner must be notified at	Funeral Director	5500 Lexington Rd. Apt.	. 211 10f. Zip Code 21207	'	USA
	er dea	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
0000	urs aft al", or Examin	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Black
5	72 hou natura	eted	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of v	working	16b. Kind of Business/Industry
7	within the the within the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		Social Security Administration
Z Z	filed v Hygie other 1		12th Grade 2years		Name (First, Middle,	
		To Be	Zach Grimes	Salo	ome Ro	200
lar y	permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any Injury or other traumatic evonce.		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or	Rural Route Numb	er, City or Town, State, Zip Code) 21133
e, ⊆	1 and Health em 27 ther tr		Pamela Blackwell/Daughter 1 20a. Method of Disposition 20b. Place	e of Disposition (Name of	Date KUL	20c. Location - City or Town, State
	ages ant of l it: If it		1 MBurial 2 Cremation 3 Removal from State			
Dallillo	mit. F partme sortan / Injur		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	aughen C.	Owings Mills, MD Greene Fundral Sewices
<u> </u>	Departi Depart Impor any Ir		Vaugn C. S	18128 Wherty Koo	ia Kanao	111510WH 1410 241 03
			23a. Part1. Enter the sease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.		diac or respiratory a	rrest, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequen			
	Examiner		URINARY	TRACT INFECT	ION	
line.	₽ =	ner		Deliaf):		
	be executed claim and bunal-transit	Examin	if any, leading to himsolate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent or as a cons	ce of).		
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00	tificate g phys	ledic	a			
S C	tendin r use	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal de			23d. Date of delivery Month Day Year
	he dea the at	by Physician/Medic	in the past 12 months? 1 □ Yes 2 □ No 4 □ Pregnant at time of deat 9 □ Unknown	h 5 ☐ Other (specify)		World Day Total
ŗ	that the part of t	y Ph	Part II. Other significant conditions contributing to death but not resulting	ig in the underlying cause given in Part I.	23e. Did 1	tobacco use contribute to the cause of death?
cords,	equires en sign		INTRACRANIAL BLEEDING		_ 1_	Yes 2□ No 3□ Probably 4□ Unknown
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<u> </u>	: The cate h	Con			perfo 1□ Yes	ormed? death? 200 No 1 □ Yes 200 No
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5	g Physer this eral di	1: To	27. Manner of Death 28a. Date of Injury 28	3b. Time of 28c. Injury at		idence 6 Other (Specify) how injury occurred
VISION	ath. or: Aftu	ation	1 Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury Work? M 1 Yes 2 No		
<u> </u>	or Atte fter de Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place of injury - At home building, etc. (Specify)	, farm, street, factory, office		(Street and Number or Rural Route Number, wn, State)
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier (Check only (Ch	edge, death occurred at the time, date and pl	lace, and due to the	e cause(s) and manner as stated.
	the H hin 24 the Fi	Medical	one) and manner stated.	29c. License number	occurred at the time.	
	7 VIII	2	29b. Signature and title of certifier	RES -00		29d. Date signed (Month, Day, Year) NOVEMBER 19 2007
1	6		30. Name and address of person who completed cause of death (Item 23			10010/100/2 10 2007
	ン		PRITAM NEUPANE MBBS, SI	NAI HOSPITAL OF	BALTI	MORE
	Sta Regist		31. Date filed (Month, Day, Year) 32 Registrar's Signature NOV 2 1 2007	South !		
			TIVE A I LOVE RETURNS	MINERAL STATES		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 19. Year **Physician** 4:45P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Saint Joseph Medical Towson Center If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days **№** M 2 🗆 F 4/23/1934 **Director** KENTUCKY 219-30-6476 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐XNo Director PARKVILLE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7708 OAKLEIGH ROAD 21234 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 【**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify Specify: þ 3 Widowed 4 Divorced WHITE "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BINDER LIFE INSURANCE permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, the once. 8TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM KEITH FREDA VELTON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD JOSEPH S. CREAGER/FRIEND 7708 OAKLEIGH ROAD 21234 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/24/2007 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY BALTIMORE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee TOWSON, MD 21286 8521 LOCH RAVEN BLVD. 23a. H.1. Enter the disease, or complications / at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau / on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PERPHEND VASCULAR DISEASE /Medical Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine RESPIRATORY FAILURE sician and burial-trans Due to (or as a consequence of) attending physician Physician/Medical the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No LACTIC ACIDOSIS 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No TRANSIENT ISCHEMIC ATTACK page 2 autopsy perform 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27 No ျှ 1 ☐ Yes 1 Nnpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

29a. Certifier (Check only one)

NOV 2

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) D31826 -Z1-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

MARYLAND 21204 OSLER DRIVE, TOWSON. RICHARD INTHICUM M. D. . 7601 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Medical

DHMH 17 Rev 1/2001

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hours after death

within 72

Maryland 21215-0036

Baltimore,

certificate be executed

Box 68760,

P.0.

Records,

Division or Vital

Physician:

e Hospital or Attendi 24 hours after death. e Funeral Director: A

To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep			
				rtificate of Death	Reg. N	2007 37247
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Vicky Lee Karns			3. Time of Death 7:15 A
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
			Fairfield Nursing Center	Crownsville If Under 1 Year If Under 24 Hrs.	O. Date of Birth	Anne Arundel
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 🖫 F 7. Age (In yrs. last birthday, Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 10/1/194	9. Birthplace (State or Foreign Country) 7 Maryland
			Usual Residence of Decedent		10/1/1/4	
	arylar	_	MD Anne Arundel Severn	ocation		10d. Inside City Limits 1 ☐ Yes 2 🎖 No
	the M	ecto	10e. Street and Number	10f. Zip Code	100 (Citizen of What Country?
	with March	בֿ	8006 Hastings Hunt Court	21144	log. v	USA
	death	nera		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
õ	or its	by Funeral Director	1 Never Married 2 Married 1 Tyes 2 No	1 Yes 20 No Specify:	rican, etc.)	Black, White, etc. Specify: White
Š	hours turel',	q pa			16h	Kind of Business/Industry
9500-61212	filed within 72 hours after death with the Maryland Hygione. ther than "natural", or flame 23a or 28a-f show ith, the Mudical Example a must be notified at	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business/industry
7 7	d with	mo	Elementary/Secondary (0-12) College (1-4or 5+) 12 2 Secr	etary	R	efuse removal
	ai Hygia I other vent, I	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	
<u>Z</u>	should be and Mental marked o	To I	William Decker		a Cline	
Maryland	C1 (0 == @	1 8		ing Address <i>(Street and Number or Run</i> 6 Hastings Hunt		·
	tem 27				-	Location - City or Town, State
Ē	permit. Pages 'Depertment of himportant: if ite any injury or of once.		ILIBURAL ZUCIONIARON SURBINOVALIRON SIARO	idge Mem. Pk. 11/2	3/2007 Elk	ridue. Maryland
Baltimore,	mit. I pertm porta			2. Name and Address of Facility Hu		
-	898		Spill Cornel 4	107 Wilkens Avenue	, Baltimon	ce, Maryland 21229
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician (Madical	i i	Immediate Cause (Final disease or condition resulting in death)	Disease		Shoot and Death
	/Medical Examiner		Due (or as a consequence of):			
		e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
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/60,	ate be executed hysician end the burial-transit	Ex	resulting in death) Last Due to (or as a consequence of):			
∞	physic physic s the b	dicai	d			
X 6	eath certific ettending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Box	death certificate e ettending phys d for use as the	Physician/Med	1 Ves 2 No. 4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
J.	by the e	hys	9 Unknown			
	The law requires thet the ide has been signed by the bage 2 should be detache	Ď	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		to use contribute to the cause of death?
Records,	requi	eted			1 🗆 Yes	
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æ		e Co	25. Was case referred to medical		1□ Yes 2	
Ξ	s certi	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	1	h (Check only one)	6 □Other (Specify)
ō	g Phy ter this		27. Manner of Death 28a. Date of Injury 28b. Time		28d. Describe how in	
<u>S</u>	ending teath. or: Alter he funer	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division of Vital	l or Attencatter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		29a. Certifier De Certifying Physician: To the heet of my knowledge, due	th consend at the time. Into and place	and flug to the cause	haland manager as stated
	Hos 1 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	red at the time, date	and place, and due to the cause(s)
	To the To the Comp	ž	29b. Signature and title of codifier	29c. License number	29d.	Date signed (Month, Day, Year)
			· SIN MA	13895	8 //	-20-2007
	V		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	15110	A MI DINI
	Sta	ate	31. Date filed (Month, Day, Year) \$32. Registrar's Signature	208 Clainth	y. 200 0/6	115011161118 21061
	Registi		NOV 2 1 2007			1-20-2007 DABUSAIC MK 2/06/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ౖ 2007 NOV. 18, 3:20 Samson Kallan 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery Rockville Shady Grove Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days Hours 1 X M 2 □ F Feb. 26,1934 73 India 230-15-2131 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 √Yes 2 No Va. Roanoke Salem 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 905 S. College Avenue 24153 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ▼ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: Asian 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Representative United Nations 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Palladi Kallan unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mariam Kallan / wife 905 S. College Ave. Salem, Va. 24153 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sherwood Mem. Park 11/23/2007 Salem, Virginia 21. Signature of Funeral Service Lighnsee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ENCEPHALOPATHY LODAYS ANOXIC disease or conditior resulting in death) Due to (or as a consequence of) 10 DAYS SEIZURE

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 is marked other the any hijury or other traumatic event, the J once.

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Director

Funeral

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Completed

Be

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Examine

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) □Yes 2 No 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Johnnown DIABETES 1. CORONARY ARTERY DISEASE Completed 2. ACUTE RENAL 5. CONGESTIVE HEART 24a. Was an FAILURE autopsy performed? Yes 2 No FAILURE 3. GANGRENE 1∐ Yes OF 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide determined 4 Homicide t 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number

if or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or within 24 hours aft To the Funeral Di

Division or Vital Records, P.O. Box 68760,

5

State Registrar

M.D. P. MATHIR D35941

29d. Date signed (Month, Day, Year)

NOVEMBER 18 2007

Month

Year

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. GOMONSTON 50 RUCKVILLE, MD 20850

31. Date filed (Month, Day, Year) 2007

NOV 2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 24b, perMD, g873, 11/21/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 17, 2007 Walter Richard Kotlowski 10:00 PM November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Months Days M 2 🗆 Hours 25, Director 141-20-5193 78 New Jersev Mar. 1929 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show be notified at 1 ☐Yes 27 No Director Maryland Harford Bel Air 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö item 27 Is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must to 1838 Wye Mills Lane 21015 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 TYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No à 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Non Commission Officer U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည UNKNOWN STELLA (UNK) _(UNK) permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 Is mar any Injury or other traumat 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ana Kotlowski / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp 11-21-07 4 Donation 5 Dother (Specify) Towson, Maryland ²² Name and Address of Facility MCComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 21. Signature of Funeral Service Licenses 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause it each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHROCKE /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and sthe burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 M80035799 Physician/Medical as 1 IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has celowski, Maiter autopsy perform - 2 X No 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 27 No 1 Thpatient မ 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director: the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier - DD H 0062765 11/18/2007 ath (Item 23a) (Type, Print) .500 Upper Chesapoake Dr. Bel Air, MD 21014 30 am dess of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

NOV 2 1 2007

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Elizabeth Lines-Browning

		1- For State Registrar	Cei	rtificate of		ıtaı riygi		000	7 0705
Physic edical Exam		1. Decedent's Name (First, Middle,Las	-7	-			Reg. I Pate of Death Month	lov. 9. 2007	3. Time of Death
euicai Exam	mer	Elizabeth Line 4a. Facility Name (if not institution, giv	es-Browning		(b. 6); . T	14	ovember 8,	2007 Year	0300 hrs
X		6307 Kirby Road	o street and number)	[b. City, Town, or Location Bethesda	of Death		4c. County of Death Montgomery	
Funeral		Social Security Number 6. S	7. Age (In yrs. I	ast birthday)		der 24Hrs. 8.	Date of Birth(N	/M/DD/YYYY) 9. Birt	hplace (State or
Director		213-13-0507	м 2X F 26	Yrs.	Months Days Hour	rs Min.	Sept. 16	, 1981 Foreig	n ^{untry)} Washi ngton
any		Usual Residence of Decedent 10a. State 10b. County	Inc. City	, Town or Locati	02				
*	_	Maryland Montgome		thesda	on .				10d. Inside City Limits 1 Yes 2 No
farylar 28a-f s at on	Director	10e. Street and Number			10f. Zip Code		10a.	Citizen of What Cour	
h the N 3a or	ig	6307 Kirby Road			20817		1	Inited Sta	·
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was	s Decedent of Hispanic On es, specify Cuban, Mexican	igin? (Specify	Yes or No-	14. Race - Americ	
ter des ", or i	. –		1 Yes 2 X No		Yes 2 X No specify		11, 6(0.)	White, etc.	
ours al atural samin	d by	15. Decedent's Education (Specify on	or Daton:	16a. Decedent	's Usual Occupation (Give	kind of work	done 16	Specify: Wh:	
36 n 72 h nan "n ical E:	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	ost of working life. DO NOT	Tuse retired)			idddiy
-003 I withing giene.	E	17. Father's Name (First, Middle, Last)	l	Sale	esperson			Retail	
215 be file ntal Hy- ked o	Be	Wesley James B	rowning				t, Middle, Maid Kathle	en Surname) en Senehi	
21 hould hould is man	၉	19a. Informant's Name/Relationship (Ty		19b. Mailing	Address (Street and Nur	mber or Rural	Route Number		Zip Code)
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene Department of Heatth and Mental Hygiene I mipportant: I fitten 27 is market other than "matural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		Marjorie Kathleen 20a. Method of Disposition			Kirby Road,			20817	
DOFE		1 X Burial 2 Cremation 3	Removal from State	crematory or oth		Novembe Novembe		c. Location - City or	Γown, State
ultir nit Pa artmer oortani		4 Donation 5 Other Specify: 21. Signature of Funeral Service License	Par		norial Park	200		ockville,	Maryland
Balt permit Depart Import		Millian a. fun	Shees _ MO117	2 1/22	ame and Address of Facilit ert A. Pumphre 7 Wisconsin Av	emile Ko	thocds	Martiand 20	evy Chase, Inc
Physician /Medical		23a. Part I. Enter the disease, or compl failure. List only one cause on each	ations that caused the death.	Do not enter th	e mode of dying, such as o	cardiac or resp	piratory arrest,	shock, or heart	Approximate interval Between Onset and
Examiner		or condition and data to describ	Smoke Inhalation						Death Death
		Sequentially list conditions, b	Oue to (or as a consequence of	n): 					
	nine	cause. Enter Underlying Cause	due to (or as a consequence of	·):					
ed sit	Examine	(Disease or injury that initiated events resulting in death) Last	due to (or as a consequence of):					
cords, P.O. Box 68760, law requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transit	edical	UNPENDED d.	AMENDED						
760, cate be ex physician the burial	/Med	IF FEMALE:	#2,28a perME g87		7 TT			20.5	
Sox 68760, leath certificate be attending physic for use as the but		23b. Was decedent pregnant in the past 12 months?	1 Live birth	-	al death 3 Ectopi	c pregnancy	[23d. Date of delivery Month Da	ay Year
Box e death c the atten ed for us	Physician	1 Yes 2 No 9 V Unknown	4 Pregnant at time of death Unknown	5 Othe	er (Specify)				
hat the ed by t	by Pt	Part II. Other significant conditions	contributing to death but not re	sulting in the un	derlying cause given in Pa	art I.	23e. Did tobaco	co use contribute to the	ne cause of death?
Is, P.C quires that en signed						_	1 Yes 2	No 3 Proba	ibly 4 🗸 Unknown
Cords, law requir has been s 2 should	Completed						24a. Was an autopsy	prior to co	ppsy findings available mpletion of cause of
tal Rection: The certificate ector, page		05.14				1	✓ Yes 2	? death? No 1 🗸 Yes	2 No
of Vital Records, ng Physician: The law require Wher this certificate has been si meral director, page 2 should b	o Be	25. Was case referred to medical examiner?	spital: 1 Inpatient 2	ER/Outpatient	26.Place of Death 3 DOA Other	(Check only of Nursing Hon			
ion of Vital Itending Physician: leath. tor: After this certif the funeral director,	-	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of Inj				dence 6 Other:	Scene
Division tal or Attendir is after death. In Director: A led in by the fu	ertification:	Natural 5 Pending Accident Investigation	FOUND: Nov. 9,	FOUND: 0249 hrs	1 Yes 2 🗸	No Victi	m of House	efire	
Division or At ours after defend Direct filled in by	ij	3 Suicide 6 Could not be	28e. Place of Injury - At hor		factory, office building, et-		ocation (Street r Town, State)	t and Number or Rura	Route Number, City
프로 등 등	OF	29a Certifier	(Specify) Single Fam			6307	Kirby Road,	Bethesda, MD	
Division To the Hospital or Attention Within 24 hours after death To the Funeral Director:	ledical	Medical Examiner:	 To the best of my knowledge In the basis of examination and an indicate manner stated. 	e, death occurre d/or investigatio	d at the time, date and pla n, in my opinion, death oc	ice, and due to curred at the ti	the cause(s) a me, date and p	and manner as stated place, and due to the	I. cause(s)
/ 5	ž	29b. Signature and title of certifier	C Stated.		29c. License number	· · · · · · · · · · · · · · · · · · ·	290	d. Date signed (Mont	h, Day,Year)
5 ,		(6 Quolden	(le)		O.C.M.E.		No	ovember 9, 2007	,
	- 1								
		30. Name and address of person who co Laron Locke MD. Assista			Street Raltimore MI	D 21201			
Sta Regist	ate		mpleted cause of death (Item 2 nt Medical Examiner 37, registrar's Signatur	111 Penn S	Street, Baltimore, MI	D 21201			

DHMH 17 Re OCME 2006

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2 1 3 7 2 5							
3.	Physici		Decedent's Name (First, Middle, Last) Thomas Lawrence	Month		2. Date of Dear Month Novembe	Day Year			
	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death		
	Funeral Director		Montgomery Hospice Casey 5. Social Security Number 579-05-2003 6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	cville If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, December	Montgome 9. Bird Co 12, 1915 Vi	ery hplace (State or Foreign untry) rginia	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits		
		Director	Maryland Montgomery Bethesda						1 ☐ Yes 2 🙀 No	
			10e. Street and Number 8738 Ridge Road		10f. Zip Code 20817			og. Citizen of What Co United Stat	•	
Baltimore, Maryland 21215-0036		by Funeral	11. Marital Status 12. Was Decer	^{2□No} WWII	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Span, Mexican, Puert		14. Race - Ame Black, Whit	rican Indian,	
		Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-12)	4or 5+) (Give	dent's Usual Occup kind of work done DO NOT use retire et Metal	during most of wor d)	king	16b. Kind of Business/		
		To Be Co	17. Father's Name (First, Middle, Last)			T	ne (First, Middle, I	Maiden Surname)		
			Constantine Lucas Florence Robinson							
			19a. Informant's Name/Relationship (Type. Print) Cheryl L. Robinson/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17400 Ryefield Court, Dickerson, Maryland 20842							
			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo	sition (Name of matory or other pla	ce) Nove	Date mber	20c. Location - City or	Town, State	
	permit. Departm Importa any Inju		21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home / Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501							
or Vital Records, P.O. Box 68760,	Physician		23a. Part1. Briter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition Colon Cancer							
	/Medical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Lipury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):						-	
	Attending Physician: The law requires that the death certificate be executed referr. referr, After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Examiner								
		edical E	d.							
		Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify)					ivery Day Year		
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the ca							
							24a. Was a autops perfori 1 Yes	sy prior to	utopsy findings available completion of cause of	
		o Be	examiner?							
			27. Manner of Death 1 X Natural 5 Pending (Month) 2 Accident investigation				esidence 6 Nother (Specify)Hospice se how injury occurred			
	i di te	Certification:	2 □ Cutates 6 □ Could not be	eet, factory, office	City or Town, State)					
	the Hospital in 24 hours in the Funeral pletely filled	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	To the within 2	Σ	Xa. (d (la -t-						igned (Month, Day, Year)	
)	5		30. Nagrie and address of person who completed cause of death (Item 23a) (Type, Print)					7, 2007		
0	11		Genevieve Anne Wroblewsk		*	r Mill Ro	oad, Rocl	kville, Mar	yland 20855	
	Sta Registr	_	31. Date filed (Month, Day, Year) 2007 32 Ge	egistrar's Signature	sele					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 14, 2007 **Physician** Eleanor M. Lide 18:21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Y **Funeral** Months Days Hours Year 1 □ M 2 1 1 F 48 1958 Maryland Director 215-66-6698 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Tyres 2 □ No Director Rockville Maryland | Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20850 United States 16 Wall Street Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🕱 Married 1 □ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: δ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Public Relations Company Producer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should bit Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev ည James T. Duncan Eleanor Hughes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Wall Street, Rockville, Maryland 20850 David A. Lide / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 □ Cremation 3 ☐Removal from State St. Mary's Cemetery Nov. 20, 2007 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, MD 20850-2805 M00896 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard failure. List only one cause on each line. Immediate Cause (Final disease or condition 1 year **Physician** Cardiomyopathy disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physician Physician/Medical as the l nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 🛛 No 9☐ Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed? certificate 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ₹ ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Medical

29a. Certifier

Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the

State Registrar

29b. Signature and title of contifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D61482

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

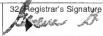
29d. Date signed (Month, Day, Year)

November 16, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6410 Rockledge Drive #200, Bethesda, Maryland Edward Healy, M.D.

31. Date filed (Month, Day, Year) NOV 2 1 2007





Physician /Medical **Examiner**

Funeral

Director

r 28a-f shov notified at

rai", or items 23a or Examiner must be

"natural"

Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, the In

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

3altimore, Maryland 21215-0036

ast use

Division or Vital Records, P.O. Box 68760.

dical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year					
ed by Pr	Part II. Other significant conditions of	contributing to death but not resulting in the	underlying cause given in Part		co use contribute to the cause of death?					
Completed				24a. Was an autopsy performed						
To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🖔 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat		ce of Death (Check only one) Nursing Home 5 Residence	a 6 □Other (Specify)					
	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Time	28d. Describe how i	njury occurred						
ertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, building, etc. (Specify)	28f. Location (Stree City or Town, S	Location (Street and Number or Rural Route Number, City or Town, State)						
Medical Certification:	29a. Certifier (Check only one) Check only one)									
Me	29b. Signature and title of certifier	1000	29c. License number		29d. Date signed (Month, Day, Year)					
	1 dan Co	willin)	D3113	16 N	OVEMBER 15, 2001					
		completed cause of death (Item 23a) (Typ	9005 KICK	BRIDE A B	OVEMBER 15, 2007 ALTIMORE, MI) 236					

State Registrar 31. Date filed (Month, Day, Year)

NOV 2

within 24 hours a To the Funeral I

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	1 _ State		Department of Health and I Certificate of Death	, 0					
5	Registrar 1. Decedent's Name (First, Middle, Last)			Reg. No. 2	007 37254				
in al	DEWEY ARTH	UR Mil	LER	Month Day	67 10:02 AM				
er	4a. Facility Name (If not institution, give street and I		4b. City, Town, or Location of Death	4c. Cou	Inty of Death				
	Franklin Square Hospita 5. Social Security Number 6. Sex	7. Age (In yrs. last birt		8. Date of Birth	9. Birthplace (State or Foreign				
	2/3367168 18 M 20 F	66	Yrs. Months Days Hours Min.	07-21-1941	Ohio Couintry)				
	Usual Residence of Decedent 10a. State 10b. County		10d. Inside City Limits						
ខ្ញុំ	Maryland Baltimore	Balt	imore		1 ☐ Yes 2 No				
Dire	10e. Street and Number		10f. Zip Code	10g. Citizen	of What Country?				
eral	8017 Babikow Road 11. Mantal Status 12. Was Do	ecedent Ever in U.S.	21237	U.S.	A . Race - American Indian,				
Be Completed by Funeral Director	1 Never Married Married 1 Yes,	Forces? s 217 No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 No Specify:	o Rican, etc.)	Black, White, etc. Pecify: White				
eted	15. Decedent's Education (Specify only highest grade complete	16a.	Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	16b. Kind o	of Business/Industry				
du		e (1-4or 5+)	iife. DO NOT use retired) ane Operator		ruction				
C	17. Father's Name (First, Middle, Last)	010	*	ne (First, Middle, Maiden Sur					
To B	Clyde Miller		Lula Al	len					
	19a. Informant's Name/Relationship (Type. Print)	1	Mailing Address (Street and Number or Ru						
	Frances Miller (Wife) 20a. Method of Disposition	20b. Place of	017 Babikow Rd Balti Disposition (Name of		7 on - City or Town, State				
	1 X Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	m State	ry, crematory or other place) S of Faith 11-1	7-2007 Balti	more, Maryland				
	21. Signature of Funeral Service Licensee) 6	22. Name and Address of Facility Sch	imunek Funera	1 Homes, Inc.				
	Suferie K	me Res	blog Belair Kd Balt	imore, MD 212	36 Approximate				
	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) 23a. Part1. Enter the disease, or complications that shock or cause of the disease or condition resulting in death)	EPSIS	nf)·	or respiratory arrest,	Interval Between Onset and Death				
_	PNEUMON, A Sequentially list conditions b.								
xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of	of):						
	resulting in death) Last C. Due	to (or as a consequence of							
cal	Cd. A	STHMA							
Med	IF FEMALE:	outcome pf pregnancy							
cian	in the past 12 months?	e birth 2 ☐ Fetal death egnant at time of death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		Date of delivery Month Day Year				
hys	9 Unknown 9 Un	known							
d by F	Part II. Other significant conditions contributing to	RE	the underlying cause given in Part I.		cco use contribute to the cause of death? 2 🔏 No 3 🗆 Probably 4 🗆 Unknown				
plete	C. DIFF COLI	Ti5		24a. Was an autopsy	4b. Were autopsy findings available prior to completion of cause of				
Com				performed? 1 Yes 2 No	death? 1 Yes 2 No				
Be	25. Was case referred to medical examiner? 1 T Ves 2 M No. Hospital:		Other:	th (Check only one)					
n: To	27. Manner of Death 28a. Da		Firme of 28c. Injury at	lome 5 Residence 6 28d. Describe how injury of					
atio	2 Accident investigation	flonth, Day Year) Ir	njury Work? M 1 ☐ Yes 2 ☐ No						
ertific	3 Suicide 6 Could not be determined 28e. Pla	ace of injury - At home, far illding, etc. (Specify)	rm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Medical Certification: To Be Completed by Physician/Medical E	(Check only 2 Medical Examiner: On the		e, death occurred at the time, date and place d/or investigation, in my opinion, death occ						
Me	29b. Signature and title of certifier		29c. License number	29d. Pate si	gned (Month, Day, Year)				
	X/m Clar	- M	031046	1.11.61	01				
	30. Name and address of person who completed ca	ause of death (Item 23a) (Type, Print), Phi Uve Ubia Rd, (JAIN, NW 21	237				
te		Registrar's Signature	1						

Registrar DHMH 17 Rev 1/2001

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State

NOV 2 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend 9,10a-f,18,206, perfH, 0873, 1174 (7) For State Amend 9,10a-f,18,206, perfH, 0873, perfH, 087 Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year MARJORIE, Mc Lachlan MAXINE, 4:16 PM NOV 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shock Trauma Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Birthplace (State or Foreign Country) 191-14-1856 1 □ M 3/□ F Months 85 Director 11/16/1922 MD PA Usual Residence of Decedent the Maryland 10b. County Howard
Allegheny 10a. State 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at **COlumbia** 10d. Inside City Limits PA MD Monroeville Director 1 ¥Yes 21€Ne 10e. Street and Number 10617 Fable Row 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be no ene. 21044 ¹⁵¹⁴⁶ 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3 Widowed 4 ☐ Divorced Specify White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teletype Operator Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Barnes Grace Mae Shrew Shew ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Kissane / Daughter 10617 Fable Row, Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Penn Lincoln Memorial 11/28/2007 4 Donation 5 Dother (Specify) North Huntingdon, PA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Charles L. Stevens Funeral Home Inc. Dovota W. Maushall 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Right temperoparietal intracranial hemorrhage Due to (or as a consequence of): **Physician** /Medical Examiner Right Frontal subdural hemorrhad Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death Day Year signed by the a 5 Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown cate has page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?

115€Yes 2□ No director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month) Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred os: 15 P M 5 ☐ Pending investigation 1 Naturai fell getting out of car 2 Accident 1 Yes 2 No 7 14/0 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10617 Fable Row, Columbia, W 4 ☐ Homicide Fable Row, Columbia, MD Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 21044 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 17418 Nov. 17, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sara M. Handy, MD
31. Date filed (Month, Day, Year) 22 Greene Baltimore, MD 21201 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 1 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08902 2007 37256 Amend #10d, 20b Ct Per FH 8/5 Department of Health and Mental Hygiene Certificate of Death Patrick Mcgrath Reg. No. 3. Time of Death 2. Date of Death Registrar

1. Decedent's Name (First, Middle,Last) Month Day Year November 17, 2007 1204 hrs Physician/ Medical Examiner Patrick C. McGrath c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Kent Chestertown 106 Kent Washington College 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5, Social Security Number **Funeral** Hours Min. Months Davs Country) Pa. April 6. 1988 19 Yrs Director 2 F 175-70-7230 1 X M 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location Yes 2XX No 10a. State 10b. County any Columbia Lancaster 28a-f show Pa. "natural", or items 23a or 28a-f sho Examiner must be notified at once. 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number 814 Chestnut Street 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. White, etc. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Armed Forces? 1 X Never Married 2 Married 2 X No Yes White Specify: Yes 2 X No specify: 4 Divorced If Yes, Give Yeer more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after c 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done ş 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) nt of Health and Mental Hygiene.

It item 27 is marked other than other traumatic event, the Medical College Student 12 +18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Caroline Shenk Gerard M. McGrath 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Be 19a. Informant's Name/Relationship (Type, Print) 814 Chestnut Street, Columbia, Pa. 17512 Baltimore, MD Marty McGrath (father 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Evans Cremation Ser. Leola, Pennsylvania 11/24/2007 1 X Burial 2 Cremation 3 Removal from State unk Important: injury or oth 4 Donation 5 Other Specify 22. Name and Address of Facility Schimunek Funeral Homes, Inc. 21. Signature of Funeral Service Licensee permit 9705 Belair Road Nottingham, MD 21236 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician Death failure. List only one cause on each line 'edical Cardiac arrhythmia Immediate Cause (Final disease áminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): # events resulting in death) Last The law requires that the death certificate be executed and X AMENDED #23a, PII, 27, perME, 28 #20b, 20c, perFH, 0874, 12/5/0 1/11/08 TI Physician/Medical tending physician a X UNPENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy Box 68760, IF FEMALE: Year Month Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) signed by the atter 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ģ Sleep apnea 24b. Were autopsy findings available Completed 24a, Was an prior to completion of cause of autopsy death? performed? 2 No certificate has 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician; 24 hours after death. Division of Vital Nursing Home 5 Residence 6 Other: Scene Other₄ Be Hospital: examiner? DOA ER/Outpatient 3 Inpatient 2 this 1 🗸 Yes 2 No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death After Certification: Yes 2 No X Natural 5 Pending the f Director: 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by or Town, State) Could not be 3 Suicide determined (Specify) within 24 hours a To the Funeral D Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 1 completely Medical one) 29d. Date signed (Month, Day, Year) and manner stated 29c, License number 29b. Signature and title of certifier November 18, 2007 O.C.M.E. Donna mu incenti , M.D. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 1 200 Registra **ORIGINAL**

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			For State Registrar		State o	f Man	yland	•			ealth and N D <i>eath</i>		gien é Reg. No.	. 0 0	1	01201
			1. Decedent's Name (Firs	st, Middle, Las	it)							2. Date of De.			r'ear	3. Time of Death
	Physici /Medio		George Fred									Nov. 18	8, 20	007		5:45 P M
	Examir	ner	4a. Facility Name (If not in Atlantic Ger						46. City, Berl		Location of Death			county of		
	Funeral Director		5. Social Security Numbe 207–42–7549	1 1	ex M 2□F	7. Age (I		t birthday) Yrs.	tf Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 06/23/	th y, Year) 1951		9. Birthpl Count	ace (State or Foreign ry) PA
0	put &		Usual Residence of Dece 10a, State 10b.	edent County		10	Oc City 7	Town or Loc	ration						10	d. Inside City Limits
7	Maryia f aho	ō		.cks			-	norne	Dation						"	1 ☐ Yes 2 ☑ No
-	r 28a-	Director	10e. Street and Number	.0120					10f. Zip	Code			10g. Citiz	en of Wh	nat Count	try?
P.LI GOT	death with the Maryiar eme 23a or 28a-f show if must be notified at	raiD	244 Hampton	Drive					190	47			USA			
101	ter dea	Funeral	11. Marital Status 1 ☐ Never Married 2	207 Married	12. Was Dece	rces?	er in U.S.	13. V	Vas Deced Yes, spec	dent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 1		- America White, e	an Indian, etc.
- 036	filed within 72 hours after death with the Maryland Hygione. Thus "natural," or items 23s or 28s-1 show ent, the Madical Examiner must be mailfied at	by	3 Widowed 4 D		1 X Yes If Yes, Giv Year or D	/e ates:		1	Yes	2 ∑ No	Specify:			Specify:	Whit	e
7.0	72 ho	eted	15. [(Specify on	Decedent's Ed	ucation de completed)		1	16a. Deced (Give	ent's Usua kind of wo	al Occupa	ation luring most of work)	sing	16b. Kir	d of Bus	iness/Ind	ustry
8005	d within piene. r then	Completed	Elementary/Secondary	(0-12)	College (1	-4or 5+)		lite. E Feache		se retired,)		Educ	catio	าก	
= 50	be filed stal Hygi of other	a	17. Father's Name (First,	Middle, Last)							18. Mother's Nam	e (First, Middle,				
Dod: 11/18/67	12 should be filed within h and Mental Hygiene. 7 is marked other than " iraumatic event, the Was	To B	George Fred								Bernice					
	47.5		19a. Informant's Name/Fi Charlene J.						-		ive, Lan					Code)
200	s 1 and 2 if Health item 27 i		20a. Method of Disposition	on		- 1	20b. Plac	e of Dispos	sition (Nan	ne of	7	Date				wn, State
23 mo			1 □ Burial 2 🖰 Cre 4 □ Donation 5 □ 0			State I		vare V			" 11/21	/2007	Sout	hamp	oton,	, PA
12018; 14/23/51	permit. Page Department of important: If any injury or		21. Signat to of Funeral	Service Licen	L Fu	en.	,)	Gai 72	Name an LY L. 50 Wa	d Addres Kaŭ shin	fman Fun gton Blv	eral Hor	ne at ridge	MMI MI	2. IN	NC. 075
8			23a. Part1. Enter the dis shock, or Heart failu	sease, or comp	olications that cone cause on e	aused the	e death.							······································		Approximate Interval Between
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0	/Medical Examiner		resulting in death)		Dueso	or as a c	onsequen	ice of):	0	2	liver					
arto		Jer	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	ns, ate	b. Due to	or as a c	ons uer	nce of :	0	-	Civer					
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49 68760.	ficate be executed physiclen and is the burial-transit	ai E	rooming in coam, case		· Due to (or as a co	on quer	ice i):							1	
17 CH		ledicai			d											
J. Pox	eath certif ettending for use a	an/N	IF FEMALE: 23b. Was decedent preg- in the past 12 month	maint	23c. If yes, out 1□Live b				Ectopic pr	egnancy			2	3d. Date Mont	of deliver	ry Day Year
70	. 5 9 9	Physician/M	1 Tes 2 No 9 Unknown	113:	4∏Pregn 9☐ Unkno		e of deat	h 5	Other (sp	ecify)				WIGHT		Day Foat
7-4 S. P.	res that igned to be deto	þ	Part II. Other significant	conditions co	ontributing to de	ath but n	ot resultir	ng in the un	iderlying c	ause give	n in Part I.					e cause of death?
707	w requir been si should	Completed										1 1	/	•		ably 4 Unknown
Nec SA	The law ate has page 2	jdmc											rmed?-	pri de	or to con ath?	ssy findings available apletion of cause of
7. E		Be C	25. Was case referred to	medical							26. Place of Deat	1 ☐ Yes th <i>Check</i> only o	2DXNo	1 [Yes	2 No
\$ \$, s ib	၉	examiner? 1 Yes 2 No			npatient		/Outpatient			4 Nursing no	ome 5□ Resid)
	7 a a a	tion:		Pending investigation		of Injury th, Day Ye	ear) 28	Bb. Time of Injury	м 2	8c. Injury Work	at ? /es 2 □No	28d. Describe f	now initury	occurre	d	
2,6e	r Attending ter deeth. frector: After by the fune	Certification:	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e. Place			e, farm, stre			2 2 110	28f. Location (S	Street and	d Number	or Rural	Route Number,
42	tal or A	Cert	4 Homicide	/	Bullai	ng, etc. (S	Specity)					City or Tov	wn, State)			
Mertz, Divis	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	Medicai	29a. Certifier (Check only one)	Certifying Phy Medical Exam	iner: On the ba	asis of ex	amination	dge, death and/or inv	occurred estigation	at the tim in my op	e, date and place, sinion, death occur	and due to the red at the time,	cause(s) date and	and man place, ar	ner as stand due to	ated. the cause(s)
_	To the within 2 To the complet	Med	29b. Signature and titte o	of certifier	A A A	ner stated	1.		290	. License	number		29d. Date	signed	(Month, E	Day, Year)
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	12,		30 Name and address of	person wito	completed caus	e of deay	1 Stem 25	(Type), F	rint)	46	xay Di	rup i	300	tin	ml.	71815
	Sta Registr		31. Date filed (Month, Da	y, Year)	32. R	egistrar's	Signatur	Som	Man !			V			-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician DOUDERDON samuel Merson 13 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ELKRICISE

If Under 1 Year | If Under 24 Hrs. handing 210 Rol Howaver 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours 1**5** M 2□ F 17 3 268160 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a, State 10b. County ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ▼ No Director MD Elkridge Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5771 Old Landing Road 21075 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: White If Yes, Give Year or Dates: '51-'52 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction the Carpenter 11 permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg. Important: If item 27 is marked other any Injury or other traumatic event; 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Oliver Merson Mary Hastings ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5771 Old Landing Road Elkridge, MD 21075 Esther Merson (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park 11/19/07 Elkridge, MD 4 □ Donation 5 □ Other (Specify) 21. Signatura Funeral Service Licensee Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd. Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Subarachwood Physician Herro orh 2 years /Medical Due to (or as a consequence of): Examiner ODGES TWE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a consequence of) Examiner be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical that the death certificate attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2XNo 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed?

1 Yes 2 No certificate or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA P this After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: A 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D4825 NOUDIN DES 16 2007

State Registrar

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Raven Blud Bla Baltimor= MV 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3900

-och 32. Registrar's Signature State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NOVEMBER 19, 2007 01:45 James Douglas Mathis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month Day, Year) SEP 12 1945 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F 62 Maryland Director 216-48-0696 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exminer must he analysis once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4016 Holly Knoll Drive 21057 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ S 2 No If Yes, Give Year or Dates: **Vietnam** 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1∐Yes 2XXNo Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Writer Advertising 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ James Mathis Gertrude Jahnke 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lou Mathis - wife 4016 Holly Knoll Drive, Glen Arm, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 11/20/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service License Steven Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD Williams Hun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betyleen Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner ul or Attending Physician: The law requires that the death certificate be executed after death. I Director: After this certificate has been signed by the attending physician and in by the Inneral director, page 2 should be detached for use as the buisal-trans. Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performe 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 300 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes poatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Marrher of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check on one) Certifying Physi ian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Exami = r: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical

filled in by To the Hospital of within 24 hours at To the Funeral D

> State Registrar

29b. Signatu

30. Name and address of par

31. Date filed (Month, Day, Year) 2007

1

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n who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles Street, Towson, MD

r: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Florence Venelda Moll 1:11 P M 13, 2007 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 3347 Cheverly Court Abingdon | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 5, 1940 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F 67 Massachusetts 218-60-9652 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director Abingdon Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21009 USA 3347 Cheverly Court Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Arthur Barrett 2 Florence Vivian Goodwin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Michael Brune / Son 3347 Cheverly Ct., Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 11-23-07 Towson, Maryland 21. Signature Uneral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Couses **Physician** Materal /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Day 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1schemic Hypertensive Hear 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? feelmenonone Diccore chronic obstructive autopsy performed? 1☐ Yes 2 No 1 ☐ Yes 2 XXNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 nours after death.

neral Director: After this
filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) . Ragueray. wo 0053720 Notember 12,10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) s. Rogeroj. NO con south Atmosp And \$100, Belock 31. Date filed (Month, Day, Year) 2007 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17, 2007 Month George Eugene Maeby Jr. November 5:22 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 13, 1925 Birthplace (State or Foreign Country)
 Maryland 1**X** M 2□ F Months Days Hours 215-14-4745 82 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 811 Delray Drive 21050 USA 12. Was Decedent Ever in U.S. Armed Forces? 1월 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: 3X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Public Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Ellen Gist George Eugene Maeby Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 813 Delray Drive, Forest Hill, MD 21050 Bonnie K. Volz / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp 11-23-07 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Embolism umpnary Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (unas a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 XER/Outpatient 3 □ DOA 1 ☐ Yes 2 No 1 [] Inpatient $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 X Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier

/Medical Examiner certificate has this within 24 hours after death.

To the Funeral Director: After t
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attending physician for use as the burial ned by the a been signed by t should be detach funeral director, page 2

Physician

/Medical

Examiner

Director

Funeral

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Certification:

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r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

marked other than

injury or other traumatic event,

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked o

Physician

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Plumtree Rd. Suite 102 Bel Air, MP 21015 S. Knig 32. Registrar's Signature 31. Date filed (Month, Day, Year)

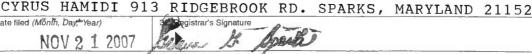
State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State Registrar

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30. Name and address of person tho completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 7 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 2007 :00A VOY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Center For HOSPICE CORE OWSon Hi more (In yrs. [ast birthday) If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1-21-194 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Mary land 219-38-2458 1**M** 2□ F Months Days Hours Min. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any Injury or other traunatic event, the Medical Eximiner must be notified at any Injury or other traunatic event, the Medical Eximiner must be notified at Baltimore 1 Yes 2 No Director 10e. Street and Number sdowne 10g. Citizen of What Country? 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ENo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced 100 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) aa 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 30b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State 07 len 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee of Home, Name and Address of Facility Balto. 21216 6th 0 Approximate Interval Between Onset and Death 23a. Part1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 1 MOhonA Marcons yens /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and debetached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Winknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 6 DOther (Specify) WSPUL P 5 Residence 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
Accident 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier License number 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TONSON MO CAMPURS in 6701 CNM45 32. Registrar's Signature 31. Date filed (Mont) State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend #10b, c&d Per FH G873 11/21/07 The Certificate of Death Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Dey Yeer **Physician** 3:15am Mildred Nicholson TOOS 18 November /Medical 4a Fecility Name (ff not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Balhmine Augsburg Lutheran Home and Village If Under 1 Year Months Days If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours 1 □ M 2 🕱 F 214-24-3061 09-01-1924 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Balto. 🖚 1XXYes 2XXVo Baltimore Catonsville Director MD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A 1012 21228 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Stetus 1 Never Married 2 Married 1 ☐ Yes 2 ☑No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: Black ģ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Domestic Engineer 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) if Haalth and Mental Nicholson 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print, 1544 Matthew Town Rd. Mildred Jackson - Niece HANOVER MD 21076 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Department of h Important: If ite any injury or off 1 Burial 2 ☐ Cremation 3 ☐ Removal from State HANOVER, HD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Meneral Service Licensee 5240 Reisterstown Rd 23a/Part1_Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical introcerebra 6 mos Examiner Due to (or es a consequence of) by Physician/Medical Examiner Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4/3 Unknown To the Mospital or Attending Physician: The law requires t within 24 bours after death.

To the Funeral Director, After this cartificate has been signs completally filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Be Completed 1 Yas 26No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:

45 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2€No Medical Certification; To 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 DNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Decrifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner steted. (Check only one) 29d. Date signed (Month, Dey, Yeer) 29b. Signature end title of certifier 29c. License number 037573 19,2007 Vovembe cause of death (Item 23e) (Type, Print) 30. Name end eddress of person who completed Restestown NO Mari 51. IEF Zibell MO 25

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32 Registrer's Signature

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			Registrar 1. Decedent's Name (First, Middle	a, Last)		erinicale or	Deain	2. Date of Deat	eg. No.	3. Time of Death	
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	Exami		4a. Facility Name (If not institution	. 5	or)	4b. City, Town, o	r Location of Death		4c. County of De		
			7803 Fairgreen 5. Social Security Number		Ann din um Inglicht	Dunda (av) If Under 1 Year		O. Data of Dist	Baltim		
	Funeral Director		216-36-2551	6. Sex 7. / 1 ☐ M 2 ☐ F	Age (In yrs. last birtho 90 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, April 1	1,1917 Mi	rthplace (State or Foreign Country) SSISSIPPI	
	pu »		Usual Residence of Decedent		40-03-7				/ ITL		
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	the Ma	rect	Maryland Balti 10e. Street and Number	поте	Dundal	10f. Zip Code		10	0g. Citizen of What 0		
	th with 23e or	ai Di	7803 Fairgreen	Road		21:	222		USA		
	ter death	Funeral Director	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S.	I3. Was Decedent of H	lispánic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh		
36	72 hours after neturel', or ite itcal Evernine	by F	1 ☐ Never Married 2 ☐ Marr 3 🔀 Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 ¶ If Yes, Give Year or Dates	-	1 ☐ Yes 2X No	Specify:		Specify: Wil	nite	
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21	within 7 ene. than "r	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4o	- lit	ive kind of work done e. DO NOT use retired	during most of workii d)	ng			
	lled w Hygier her th		12 years 17. Father's Name (First, Middle,	2 years		Housewife	40 Motheda Nama		Own Home		
Maryland	should be filed within and Mental Hygiene. s marked other than " umatic event, the Men	o Be	Walter P. Gray	_ast)			18. Mother's Name	-	•		
ary	should and Me mari umati	٩	19a. Informant's Name/Relations	nip (Type, Print)	19b. M	ailing Address (Street				Zip Code)	
Ž	and 2 salth a 127 ls	22	Anna Estes	Daughter	341	2 Sollers 1	Point Road	l, Dunda	lk,Maryla	nd 21222	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "neturet", or items 23e or 28a-f shown injury or other traumatic event, the Medical Evantinet must be rediffed at ance.		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation	3 □Removal from Sta		sposition (Name of crematory or other place	Novem	ate iber	20c. Location - City o	r Town, State	
I i i	it. Pa rtmen rtant: njury		* 4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service		Bayview	Crematory	21,		altimore (
Ba	permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 Is man eny injury or other traumat ODGE.		In Ence			22. Name and Addre Connelly 1 7110 Solle	Funeral Ho ers Point	me Of Di Road, D	undalk,P. <i>R</i> undalk,MD.	21222	
			23a. Part . Enter the disease, or sick, or heart failure. List	complied tions that caus only one cause on each	ed the death. Do not line.					Approximate Interval Between	
	Physician ' /Medical		Immediate Cause (Final disease or condition resulting in death)	a	CANCER					2 MONTHS	
	Examiner			Due to (or a	is a consequence of):						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	is a consequence of):						
/	ecuted and transi	Examiner	cause. Enter Underlying that initiated events resulting in death) Last	с							
38760,	icate be executed physician and s the burial-transit	ai Ey	resulting in deathly cast	Due to (or a	is a consequence of):						
687		edicai		d							
Вох	eath certific attending pl	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		3 □Ectopic pregnancy			23d. Date of de	23d. Date of delivery	
O. B	The law requires that the death certif te has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown			5 Other (specify)			Month	Day Year	
P.0	res that the de signed by the a be detached f	Phy	Part II. Other significant conditio	ns contributing to death	but not resulting in th	e underlying cause giv	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?	
Records,	quires n sign uld be	d by						1 □ Ye	s 200 No 3□F	Probably 4 DUnknown	
000	aw requir is been si 2 should	Completed						24a. Was an	24b. Were a	utopsy findings available	
		Com						autopsy perform	ned? prior to death?		
Vital	Physicien: r this certifica ral director, I	Be	25. Was case referred to medical examiner?	Hoopitaly			26. Place of Death	(Check only one	9)		
of	this ald	-: To	1 ☐ Yes 2 🕱 No 27. Manner of Death	Hospital: 1 ☐ Inpa			4 Nuising Hon		nce 6 Other (Sp w injury occurred	ecify)	
ion	nding I nth. :: After e funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investig	(Month, E	ay Year) Injur	y Wor	k? Yes 2 □ No	34. 20001.50 110	w injury occurred		
Division	r Attendii er death. rector: A by the fu	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of I	njury - At home, farm, etc. (Specify)	street, factory, office	2	8f. Location (Str. City or Town,	eet and Number or F	Rural Route Number,	
ā	itel or A rrs after rel Dire lled in b)										
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Medical	29a. Certifier (Check only one) Certifying 2 Medical E	g Physicien: To the bes examiner: On the basis and manners	of examination and/or	eath occurred at the tin r investigation, in my o	ne, date and place, a pinion, death occurre	nd due to the ca d at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier	./ 1		29c. License	e number	29	d. Date signed (Mor	ith, Day, Year)	
,			men.	Hayash	MD	0620	32	N	DVEMBER	20,2007	
19	0			who completed cause of	death (Item 23a) (Typ	pe, Print)		0:-		10 21224	
	Sta	te	JENNIFER H 31. Date filed (Month, Day, Year)	KYNSHI 5	trar's Signature	NS RAYVIE	NCIRCLE	DALT	IMORE P	11) WHY	
	Registr		NOV21	2007	a K	boots					

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Jodi Diane Olejar	

odi Diane Oleja	r	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2007 3	726
Physicia Medical Examii			
		4a. Facility Name (if not institution, give street and number) Howard County General Hospital 4b. City, Town, or Location of Death Columbia Howard	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State	
_		Usual Residence of Decedent	
id how any	_	10a. State10b. County10c. City, Town or Location10d. Inside CMarylandHowardElkridge1 Yes	
he Maryland or 28a-f show	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7822 Edmunds Way 21075 USA	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she market other than "natural" and the motified at once	Funeral		ack,
	þ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Project Manager Constellation End	erov
21215-0036 uld be filed within 7 Mental Hygiene marked other than			67
212' ould be i Mental marke	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
, MD and 2 sho ealth and em 27 is		Robert Olejar Husband 7822 Edmunds Way; Elkridge, Maryland 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	
Baltimore, permit. Pages I an Department of Hea Important: If iten		1 Burial 2 Cremation 3 X Removal from State crematory or other place)	daan
Saltir ermit. I Departmo mporta		21 Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Witz	ke
Physician	4	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate	te Interval
/Medical :aminer		failure. List only one cause on each line. Myocarditis complicated by myocardial fibrosis and focal Immediate Cause (Final disease or condition resulting in death) Between O Dea	
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
ted I msit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	
'60, ate be executed bhysician and te burial - transit	dical	\(\forall \text{ unpended}\) \(\forall \text{ amended}\) \	
c 687 certific ending p		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	Year
). Bo): the death by the att	ا≨	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.	leath?
ires that signed by the detail	ğ	1 Ves 2 No 3 Probably 4 U	
of Vital Records, ng Physician: The law require. The this certificate has been simeral director, page 2 should be	Completed	24a. Was an autopsy findings autopsy prior to completion of completion o	cause of
tal Rection: The lectificate lector, page	S B	25. Was case referred to medical 26.Place of Death (Check only one)	No No
of Vit ing Physic After this	ျ	1 Ves 2 No Tospital 1 Inpatient 2 V ER/Outpatient 3 DOA VIII 4 Nursing Home 5 Residence 6 Other:	
ion C tending eath. tor: Af the fun	ation	1 X Natural 5 Pending (Month, Day,Year) 1 Yes 2 No	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Numor Town, State)	nber, City
To the Hos within 24 h To the Fun completely	ledical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
F S F O	¥	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) November 18, 2007	
OCME		30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta Registr		31. Date filed (Month, Day, Year) 32. Degistrar's Signature	

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

			For State Registrar	State of Ma	-	epartment of F Certificate of			giene Reg. No.∕⊃ ∩ ∩ ∶	7 27260	
			Decedent's Name (First, Middle, Last	st)				2. Date of Dea	ath 200	3. Time of Death	
	Physicia		John Joseph O'Br	ien				Month Noveml	Day Yes	6.20 7344	
4	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of D		
1			7807 Charleston	Drive			Bethesda		Montgo	mery	
	Funeral		5. Social Security Number 6. S		(In yrs. last birth			8. Date of Birth	h 9.1	Birthplace (State or Foreign Country)	
h	Director		126-16-7898 Usual Residence of Decedent	Ø M 2□F	80 Yr	s. Months Days	Hours Will.	10/20		IY	
	yland how at		10a. State 10b. County		10c. City, Town o	or Location				10d. Inside City Limits	
	Mar a-f sl ified	Director	MD Montgor	nery	Bethes	da				1 ☐ Yes 2 No	
	th the	ire	10e. Street and Number	-		10f. Zip Code			10g. Citizen of What	Country?	
	h wit	<u>a</u>	7807 Charleston	Drive		20817	-		USA		
	dear ms	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Spo	ecify Yes or No-	14. Race - A	merican Indian, /hite, etc.	
38	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 ☒ No		riloan, oto.j	Specify:	White	
21215-0036	72 hou	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. D	ecedent's Usual Occup Give kind of work done ife. DO NOT use retire	nation during most of work	ing I	16b. Kind of Busine		
121	within ene. than '	Jdmo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	ife. DO NOT use retire wyer	d)		Corporat	e Law	
р П	Hygid Hygid ther ant, ti	ပ္	17. Father's Name (First, Middle, Last)			wycı	18. Mother's Name	First, Middle,	Maiden Surname)		
an	d be ental red o	o Be	Michael T. O'Brie				Mary T.	Hannaha	n		
Maryland	ind Me	၉	19a. Informant's Name/Relationship (19b. N	Mailing Address (Street	and Number or Run	al Route Numbe	er. City or Town. Stat	te. Zip Code)	
<u>≅</u>	rd 2 s Ith ar 27 is trau		Roberta J. O'Brie		I	307 Charles					
ē,	Hea Hea tem	-	20a. Method of Disposition			isposition (Name of crematory or other pla		Date	20c. Location - City		
Baltimore,	Pages nent of ant: If I		1 ☐ Burial 2 【Sucremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			crematory or other pla peake Crema	1	Nov 20 2007	Beltsvill	le, Maryland	
Balt	permit. Departimonts any inj once.		21. Signature of Funeral Service Licer	100	00382		ral & Crem	ation Se	rvices	3 20010	
	-			pications that caused	the death. Do no	933 Gist .			g, Marylan	Approximate	
	17.106		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line	θ. Λ	ES CONSAN	7-7-	,	,	Interval Between Onset and Death	
7	Physician /Medical		disease or condition resulting in death)	a. HOT	te to	reury	m				
	Examiner			Due to (or as a	consequence of)	0					
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying									
γ.	cuted	Examiner	Cause (Disease or injury that initiated events	c							
Ö	ian a	Ē	resulting in death) Last								
68760,	ficate be executed physician and is the burial-transit	edical		.d							
_	± 0.6		IF FEMALE:	220 If yes outcome r	of pregnancy						
Вох	ath c	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p	2 🗆 Fetal death	3 Ectopic pregnanc	у		23d. Date of Month	•	
o.	The law requires that the death cert ate has been signed by the attending age 2 should be detached for use a	Physician/M	1 Yes 2 No	4□Pregnant at t 9□Unknown	time of death	5 Other (specify)					
ם,	that led by deta		Part II. Other significant conditions of	ontributing to death bu	t not resulting in the	ne underlying cause giv	en in Part I.	23e. Did to	obacco use contribut	e to the cause of death?	
Records,	uires r sign ld be	d by	dypertensi	ion				1 🗆 1	Yes 2 No 3 □	Probably 4 Unknown	
<u></u>	w requir been si should b	lete	RICER	and of	10-1-	. O.		24a. Was	an 24h Were	e autopsy findings avaitable	
Re	rsician: The law s certificate has t lirector, page 2 s	Completed	Sevice	astale Al	Spexicel	Mu		autop perfo	prior rmed2 deati	to completion of cause of h?	
Vita			25. Was case referred to medical				00 Di(D		2127No 1□1	Yes 2□No	
	sicia certi recto	Be	examiner?	Hospital:	nt 2 ER/Outp	etient 3 DOA Oth	26. Place of Deatl			2	
ō	Phys r this ral dir	٦. ا	27. Manne of Death	28a. Date of Injury					dence 6 Other (S	эреспу)	
Division or	Attending Physician: The r death. ector: After this certificate he by the funeral director, page	tion	1 ► atural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Inju		rk? Yes 2 ☐ No				
S	or Attendater death Director: in by the	ţica	3 Suicide 6 Could not be determined	Zoe. Flace of inju	ry - At home, farm	, street, factory, office		28f. Location (S	Street and Number o	r Rural Route Number,	
ă	a # # #	Certification:	4 Hornicide	building, etc.	. (Ѕреспу)			City or Tov	vn, State)		
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical (ysician: To the best o niner: On the basis of and manner stat	examination and/						
	To the within to the complete	M	29b. Signature and little of certifier			29c. Licens	se number		29d. Date signed (M	Ionth, Day, Year)	
	. 11		30. Name and address of person who	completed cause of de	ath (Item 23a) /Tv	/pe. Print)	0000		/ vovero	911,2001	
	61,		Revi Passi 1	ND 86	09 Sec	ond ave	#4047	3 Sul	ver Spra	ng NBOG10	
	Sta Registr		31. Date filed (Month, Day, Year)	107 32 distra	r's Signature	Grand)	•		,		
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State Registrar 31. Date filed (Month, Day, Year)

NOV 21

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, 37270 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** O'Connor John Joseph November 16 2007 10:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5002 Westland Boulevard Apt. <u> Arbutus</u> Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1**X** M 2 ☐ F Director 212-26-7649 12/28/1929 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show aţ notified Director 1 ☐ Yes 2 No Maryland Baltimore Arbutus 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 5002 Westland Boulevard Apt. C 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 **½**Yes 2 □ No If Yes, Give Year or Dates: 1948–52 1 Never Married 2 Married 1 ☐ Yes 2 🛂 No Maryland 21215-0036 Specify. ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any Injury or other traumatic event, the Med once. Elementary/Secondary (0-12) College (1-4or 5+) 10 Firefighter Baltimore City 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William O'Connor Blanche Sheeler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Colleen E. Utzig / Daughter 1213 Weddel Avenue Baltimore, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore National Cem. 11/20/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Hubbard Funeral Home, Inc.
4107 Wilkens Avenue Baltimore, MD
pproximate Interval Between Onset and Death 22. Name and Address of Facility
Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee Marle T. 23a. Part1. Enter the disease, er complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner be executed J physician and s the burial-trans P.O. Box 68760,5 Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has t page 2 s autopsy performed Yes 2 certificate 1∐ Yes Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 2 No 1 ☐ Yes ို 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE BALTIMORE MD 900 CATON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 1 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** ph 12. J05 E 18822 00466 M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 XM 2 ☐ F Director 521-64-5043 58 March 21, 1949 Colorado Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ratural" or Items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at any Injury or other traumatic event; the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2841 Willow Lane 21043 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 □ No Specify. þ Specify.White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Telecommunication 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joe M. Perez Bessie Martinez ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2841 Willow Lane; Ellicott City, Maryland 21043 Wife Joyce Perez 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/21/2007 Metro Crematory Catonsville, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee Lenner 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ACITE /Medical Due to (or as a consequence Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician. The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural within 24 hours aller control to the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

one)

755 CEDAR CANE 32. Registrar's Signature

30. Name and address of person who completed cause of eath (Item 23a) (Type, Print)

29c. License number

038026

Columbia, MA 21044

29d. Date signed (Month, Day, Year)

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Registrar
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timore

St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CONTON

31. Date filed (Month, Day, Year)

22

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Greene

32. Pegistrar's Signature

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State

Registrar

31. Date filed (Month, Day, Year)

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2. Registrar's Signature

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Potts

Bernard

37275

3. Time of Death

Phy	sician
/N	ledical
Exa	aminer

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executer within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 20

Division or Vital Records, P.O. Box 68760,

	Rogers				November	17 2007	2148 PM			
4a. Facility Name (If not institut Johns Hopkins P	ion, give street and number) Sayview Medica	Center	4b. City, Town, o	r Location of Death		4c. County of Death				
5. Social Security Number 253.66.4512 Usual Residence of Decedent	1 25 M 2□ F	je (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 06 . 25 . 1	ar) Cou	place (State or Foreign Intry)			
10a. State 10b. Coun	ty	10c. City, Town or Lo	ocation				10d. Inside City Limits			
FL Palm	n Beach	Boca	Raton				1 Yes 2 No			
10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	intry?			
860 N.E. Orc	hid Bay Dr	ive	33487		11	S.A.				
11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Bican, etc.)	14. Race - Ameri Black, White,				
1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give	NO	1 ☐ Yes 2 No	Specify:	, , , , , , , ,	Specify: Whi				
	ent's Education	16a Daca	dent's Usual Occup	ation	401					
(Specify only high	nest grade completed)	(Give	kind of work done DO NOT use retired	during most of worki d)	ng	. Kind of Business/In	idustry			
Elementary/Secondary (0-12)	College (1-4or 5	P+) L _		onsultar		nsumer G	200ds			
17. Father's Name (First, Middle	e, Last)		,		(First, Middle, Maid		10003			
Jesse Richa	rd Rogers			Marv Ne	elle Gra	ves				
19a. Informant's Name/Relation	nship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Rura	Il Route Number, Ci	ty or Town, State, Zip	o Code)			
June Oglesby	-Rogers/wi	fe 860	N.E. Or	chid Bay	Dr R	oca Rato	33487			
20a. Method of Disposition	3 □Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place	ce)	ate 20c	oca Rato Location - City or To	own, State			
4 □ Donation 5 □ Other		1			0.07 Be	ltsville	MD			
21. Signature of Funeral Service	e Licensee	22	2. Name and Addres	ss of Facility Cre	mation	And Fune	ral Balt			
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
Immediate Cause (Final disease or condition	Ac. to	- Respirato	7	ess Syndra		3	Onset and Death			
resulting in death)	Due to (or as	a consequence of):	1	- /1/03	١٣٠		1 Weck			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		8 years								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23d. Date of delivery Month Day Year								
Part II. Other significant condit		it not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?			
Chronic Fre	istitul Nephri	itis			1 ☐ Yes	2 No 3 Prob	ably 4 □Unknown			
11 1	Diabetes (5)	teroid Induce	(4.		24a. Was an autopsy performed	24b. Were auto prior to cor death?	psy findings available mpletion of cause of			
Hypertension										
	ngenosum				1□ Yes 2	No 1 ☐ Yes	2 □ No			
25. Was case referred to medic examiner?	al Hospital	at 2 50/Outration	Othe	26. Place of Death	1 Yes 2 X (Check only one)					
25. Was case referred to medici examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi	al Hospital: 1 Inpatier 28a. Date of Injur	y 28b. Time of	28c. Injury Work	er: 4 🗆 Nursing Hom	1 Yes 2 X (Check only one)	6 □Other (Specif				
25. Was case referred to medici examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	Hospital: 1 Inpatier 28a. Date of Injur (Month, Day	y 28b. Time of Injury	28c. Injury Work	er: 4 Nursing Hom rat 2 ? res 2 No	1 Yes 2 X. (Check only one) ne 5 Residence 8d. Describe how in	6 ☐ Other (Specifing in the specifing in the specific in the	y)			
25. Was case referred to medicion examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could 4 Homicide detern 29a. Certifier 1 Certifyi	al Hospital: 1 Inpatieu 1 28a. Date of Injur (Month, Day igation not be lace of injured 28e. Place of injured	y Year) 28b. Time of Injury ry - At home, farm, stre. (Specify) f my knowledge, death examination and/or inv	28c. Injury Work M 1 1	er: 4 Nursing Hom	1 Yes 2 X (Check only one) ne 5 Residence 8d. Describe how in 8f. Location (Street City or Town, Sta	6 □Other (Specifing occurred and Number or Ruralite)	y) Il Route Number,			
25. Was case referred to medicion examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pendi invest 3 Suicide 6 Could 4 Homicide detern 29a. Certifier (Check only) 2 Medica	Hospital: 1 Impatien 1 Manpatien 1 Manpatien 28a. Date of Injur (Month, Day 1 gation not be nined 28e. Place of injur building, etc 1 Examiner: On the basis of and manner star	y Year) 28b. Time of Injury ry - At home, farm, stre. (Specify) f my knowledge, death examination and/or inv	28c. Injury Work M 1 1	er: 4 Nursing Hom y at 2 ? Yes 2 No 2 ne, date and place, a pinion, death occurre	1 Yes 2 X (Check only one) ne 5 Residence 8d. Describe how in 8f. Location (Street City or Town, Sta	6 □Other (Specifing occurred and Number or Ruralite)	tl Route Number, tated. to the cause(s)			
25. Was case referred to medici examiner? 1 Yes No 27. Manner of Death 1 Natural	Hospital: 1 Impatien 1 Manpatien 1 Manpatien 28a. Date of Injur (Month, Day 1 gation not be nined 28e. Place of injur building, etc 1 Examiner: On the basis of and manner star	y Year) 28b. Time of Injury ry - At home, farm, stre. (Specify) of my knowledge, death examination and/or invited.	28c. Injury Work M 1 1 2 Deet, factory, office a occurred at the time restigation, in my of	er: 4 Nursing Hom y at 2 ? Yes 2 No 2 ne, date and place, a binlon, death occurre	1 Yes 2 (Check only one) ne 5 Residence 8d. Describe how in 8f. Location (Street City or Town, St. and due to the cause of at the time, date at the time, date at 29d. □	6 □Other (Specifing plants) and Number or Rural ate) ((s) and manner as signed place, and due to Date signed (Month,	tated. the cause(s) Day, Year)			
25. Was case referred to medici examiner? 1 Yes No 27. Manner of Death 1 Natural	Hospital: 1 Impatien 1 Monpatien 28a. Date of Injur (Month, Day 1 gation not be nined 28e. Place of injur building, etc 1 Examiner: On the basis of and manner star	y Year) 28b. Time of Injury ry - At home, farm, stre. (Specify) of my knowledge, death examination and/or invited.	28c. Injury Work M 1 1 2 Deet, factory, office a occurred at the time restigation, in my of	er: 4 Nursing Hom y at 2 ? Yes 2 No 2 ne, date and place, a pinion, death occurre	1 Yes 2 (Check only one) ne 5 Residence 8d. Describe how in 8f. Location (Street City or Town, St. and due to the cause of at the time, date at the time, date at 29d. □	6 □Other (Specifing plants) and Number or Rural ate) ((s) and manner as signed place, and due to Date signed (Month,	tated. the cause(s) Day, Year)			

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State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

eç	ory Rogers		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2007 372
Mad	Physicia dical Exami	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year 0800 brs
viet V	aicai Exami	Hei	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Europal	4	1638 East 30th Street Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
	Funeral Director		218-88-2088 1X M 2 F 42 Yrs. Months Days Hours Min. 08/24/1965 Foreign Country) MD
	any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
7	faryland 28a-f show 1 at once.	ģ	NC Edgecombe Tarboro 1 x Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
100	ith the Maryland 23a or 28a-f sho notified at once.	1 Director	1205 St. Patrick Street 27886 USA
	fter death wi	y Funeral	11. Marital Status 1
	5-0036 ted within 72 hours a Tygiene. other than "natural the Medical Examin	ted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
٠	036 rithin 72 rne. r than '	Completed	12 Carpenter Self Employed
	21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Collins Rodgers 18. Mother's Name (First, Middle, Maiden Surname) Nannie Lyons
	more, MD 212: Pages 1 and 2 should be nent of Health and Menta ant: If item 27 is marke or other traumatic even	5	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	e, MD 2 I and 2 shou Health and M item 27 is n		Nannie Rodgers / Mother 1205 St. Patrick Street, Tarboro, NC 27886 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
	Baltimore, MD 2 pernit. Pages I and 2 shoul Department of Health and Iv Important: If item 27 is minjury or other traumatic.		1 Name of the plac
	Balt permit. Depart Import injury		21. Signatur of Fineral Service Licencee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230
	Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and
•	taminer	1	Immediate Cause (Final disease or condition resulting in death) A Heroin intoxication and ethanol use Due to (or as a consequence of):
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
		Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
	60, ate be executed hysician and e burial - transit	Sal Ey	d,
	'60, rate be e physicia he buria	Medi	IF FEMALE: AMENDED #1,23a,27,28a-f, perME,g874, 12/4/07 TT 23c. If yes, outcome of pregnancy 23d. Date of delivery
	Box 68760, e death certificate be ex the attending physician of for use as the burial	ician/	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (Specify) Month Day Year
	O. Bo; it the deatl by the att ached for	Physician/Medical	Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
	P.O.	þ	1 ☐ Yes 2 ✓ No 3 ☐ Probably 4 ☐ Unknown
	cords, law requir has been s 2 should	Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death?
	Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the this certificate has been signed by the attending physician and the Funeral Director: After this certificate has been signed by the attending physician and inplietly filled in by the funeral director, page 2 should be detached for use as the burial - transitions.		1 Ves 2 No 1 Ves 2 No 25. Was case referred to medical 26. Place of Death (Check only one)
	Vita hysician this cer	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene
	nding Ph th. r: After t		27. Manner of Death 1 Natural 5 Pending Investination Production Injury (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 X No unk 28d. Describe how injury occurred unk
	ivision or Attendather death Director:	Certification:	2 Accident Investigation The TT/ TO/ 2007 The 7.50 all 286. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
	Di lospital 4 hours a 'uneral I		Suicide 6 X Could not be determined (Specify) found at residence or Town, State) 1638 E. 30th St. Baltimore, MD 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
ď		Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 18, 2007
	OCME		30. Name and address if person who completed cause of death (Item 23a)
	S:	ate	Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature
	Regis	trar	NOV 2 1 2007 January & January 1
DH	HMH 17 Rev 1/2	001	ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 23a per dr., g873, 11/21/07/dbb 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 7 Year 1007 ROBINSON 09:03 AM **Physician** JOYCE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE BAUTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6 Sex **Funeral** 1 M 2 214-56-7052 Director 12 · 30 · 195 1 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b, County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 No 2 No WD Baltimore Funeral Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Potomac Street

12. Was Decedent Ever in U.S.
Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any Injury or other trainer. ala P 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 2 Ho
If Yes, Give
Year or Dates: 1 ☐ Yes 2 ANO Snecify. þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Securi Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peason James M. Probinson aveen E. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1239 N. Potomac St Baltimore MD 21213
of Disposition (Name of Date 20c. Location - City or Town, State Queen E-Rabinson/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11.14.2007 Baltimore, MI 4 □ Donation 5 □ Other (Specify) King Memorial Hark 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Voughn C Greene Function Services 4905 York Acad Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BRAIN INJURY PNOXIC 2 weeks **Physician** /Medical Examiner RESPIRATORY DISTRUS SYNDROME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Preumonia 3 weeks Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 more Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 221No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death Certification: 28a Date of Injury 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day Vear) 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 5-000 NOVEMBER 7, 2007 600 NORTH WOLFE STREET cause of death (Item 23a) (Type, Print) THE JOHNS HOPKING HOSPITAL BREELYN WILKY RALTIMORS MAKYLAND ZIZP7 4M 31. Date filed (Month, Day, Year) NOV 2 1 2007 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Ellis Robinson 11 07 /Medical 16 Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Pikesville Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Months Min. Days Hours **Director** 06 13/1927 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at MD Baltimore Randallstown 1 ☐ Yes 2 X No Director 10e_Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Marriottsville Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status th and Mental Hygiene. 7 is marked other than "natural", or iten traumatic event, the Medical Examiner 1 XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: Black 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baitmore Elementary/Secondary (0-12) College (1-4or 5+) Schools 8 years rincipal 17. Father's Name (Elst, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellis Robinson, Sv. Man Boud ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Jural Route Ymber, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trauonce. Drive Windsor Mill, MD 21244 3501 Mtadowdale 20b. Place of Disposition (Name of cemetery, crematgry or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5ykesville, MD akeview Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vougin (. Greene Funera) Services 21. Signature of Funeral Service Licensee Road andalistan MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MITATE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in doubt) Leat Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-trans Division or Vital Records, P.O. Box 68760, resulting in death) Last Due to (or as a consequence of): physician Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 9☐Unknown Month Year 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼ No 24a, Was an page 2 s certificate 1□ Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 42 Nursing Home Certification: To 5 ☐ Residence 6 ☐ Other (Specify) After this within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mille 1/20107 D47683 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kaymon Miller 25 Main Street Sinte

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32. Registrar's Signature

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KENNETH RODEN

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year) State

32. Registrar's Signature

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year November 10 2007 W. Salmon Thomas 6:45 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Nursing & Rehab. Burtonsville If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign XXM 2□F 80 Illinois 346-20-5052 Feb.24,1927 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 7260 Eden Brook Drive #C104 21046 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛱 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry Power Systems & 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Controlls Electrical Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eleanor Walsh Thomas T. Salmon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 7260 Eden Brook Drive #C104, Columbia, MD 21046 Mary K. Salmon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Columbia Mem. Park 11/19/2007 Columbia, Maryland Witzke Funeral Home, Inc. 21. Signature of Funeral Service Licensee 5555 Twin Knolls Rd., Columbia, Maryland 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Disease Cordiovascular Many yrs. disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter or carrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Advanced 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

be executed burial-tran Box 68760, physician as the t signed by the attending of the detached for use as P.O. Division or Vital Records, neec has page 2 Physician: this funeral After death. To the Hospital or Attend within 24 hours after death To the Funeral Director; the filled in by

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Certification:

Medical

5 Pending investigation 2 ☐ Accident 1 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

3 ☐ Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title obcertifier MD

determined

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29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500 Greenwey Cntr. D Kern, 12 MD Greenbelt. ur 31. Date filed (Month May) Year) 1

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37282 Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 8:50 P M Norman Anthony Smith Sr. November 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 13 Singer Road
5. Social Security Number 6 Harford Abingdon 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days 1 M 2 ☐ F 218-34-0979 68 31, 1939 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Abingdon Harford 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Singer Road 21009 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: Specify. 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Freight Rate Specialist U.S. Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Stanley Smith Helen Vera Archer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nerissa A. Gaume / Daughter <u>13 Singer Road, Abingdon, MD 21009</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George's Epis. Cem. 11-19-07 Perryman, Maryland 21. S nature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myccordict disease or condition resulting in death) Bearing Jud Due to (or as a consequence Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 25. Was referred to m dical examiner? death? 1 ☐ Yes lipidemi 26. Place of Death Check onl one Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

Physician /Medical Examiner

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To the Funeral Director: After thi completely filled in by the funeral

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Department of Health and Mental Hygin Important: If item 27 is marked other any Injury or other traumatic event, tt once.

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

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Funeral

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Completed

Examine and burial-tra ed by the attending physician detached for use as the buria Physician/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

> 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 29b. Signature and title of certifier

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

MD

De056607

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. ATUSOD Rd, BEL ASR MD 21014 602 JUSEPH MNGELO, # 205 31. Date filed (Month, Day, Year)

Registrar

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5 ☐ Pending investigation

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I	Physici /Medic		Decedent's Name (First, Middle, Last) Madeline E. Se	chreiber			2. Date of De. Month Novembe	Day Year	3. Time of Death 4:40 P M
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	Funeral Director		1 □ M 2 1 1 E)4 Yrs.	Months Days	Hours Min.	8. Date of Bin (Month, Da Aug • 21	y, Year) 1913 Ne	rthplace (State or Foreign ountry) WYORK
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic avent, the Medical Examinar must be notified at once.	L	10a. State 10b. County 10c	c. City, Town or Lo	cation				10d. Inside City Limits
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36		by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 1 Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar		ecify Yes or No Rican, etc.)	Specify:	ite, etc.
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	To t Com	≥ :	29b. Signature and title of certifier			number 5579		November	
12	-		30. Name and address of pers who completed cause of death Susan J. Miller, M.D. 6844	Tulip Hil	Print) 1 Terrace	e, Bethes	da, Mar	yland 208	16
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	Director		219-10-3428									, 19	924 Maryland				
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10	7		30. Name and address of person who	completed cause of	death (Ite	232) (Туре,	Print)										
1)		Dorothy Seay, M.D	., 2835 S			#203	3, Ba	altimo	ore,	Mary1a	nd 2	1120)9			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 16, /Medical Shefali Sengupta 2007 08:05 November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2√2 F Yrs. Director 213-06-1979 78 February 19,1929 India Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show at r than "natural", or Items 23a or 28a-f sh the Medical Examiner must be notified 1 ☐ Yes 2√ No Director Gaithersburg Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16509 Sioux Lane 20878 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No þ Specify: Asian Indian 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the gone. 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tejendra N. Gupta Pushpa Gupta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ranjit K. Sengupta / Son 16509 Sioux Lane, Gaithersburg, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) November 19 Montgomery Crematorium 2007 Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M01346 23a. Fartt. En et the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure 6 Hours /Medical Due to (or as a consequence of): Examiner Idiopathic Pulmonary Fibrosis 5 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed and Due to (or as a consequence of) physician Physician/Medical 38 attending p 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Coronary Artery Disease Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? certificate 1∐ Yes 2 X No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo မှ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital Records, P.O. Box 68760. Hospital or Attending within 24 hours after death

To the Funeral Director:
completely filled in by the

State Registrar (Check only one)

29b. Signature and title of certifier

NOV21

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11125 Rockville Pike #208, Rockville, Maryland 20852-3142 Safy John, MD 31. Date filed (Month, Day, Year)

32 Registrar's Signature

and manner stated.



29c. License number

D00057954

29d. Date signed (Month, Day, Year)

November 20, 2007

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** George Shenk Α. 18 2007 November 05:00A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 270 Creek Blvd. Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) May 21 19 **Funeral** Months 1 M 2 ☐ F 227-10-2185 94 1913 Director VA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Pasadena Anne Arundel Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with Hygiene. 270 Creek Blvd 21122 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 LYes 2 ☐ If Yes, Give Year or Dates: 2 🗀 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any Injury or other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Westinghouse Electronic Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Abram Shenk Samantha Showalter ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elsie Shenk 270 Creek Blvd., Pasadena, MD 21122 (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Nov. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemi. 2007 Crownsville, Maryland 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 mountaih Road, Pasadena, MD 21122 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest istory one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, shock, or heart failure. Due to (or as a consequence of Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and hed for use as the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an certificate has autopsy performed? 1 Yes 2 No page, funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2X No ို 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospital or Attending in 24 hours after death.
the Funeral Director: After Injury 5 Pending investigation 1 TYes 2 No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 056950 Physizian 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Madison Park Drive Snite 16 Hen Brynie MD 2000 411 wo vnaemella 32 Registrar's Signature State Registrar 2007

law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

with the Maryland

S

eLVIN

Maryland

Baltimore,

or Attending Physician: The 24 hours after death Funeral Director: filled in by To the Hospital completely within 2

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D006190

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 FRANKLIN Baltimore EBO Drive MO 21237 Chukwuma M.

State Registrar 31. Date filed (Month, Day, Year) NOV21 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of DVR 8873 11/20/0 Certificate of Death

Red No. 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Maryland Medical 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at 1 ☑ Yes 2 ☐ No Director timore 10g. Citizen of What Country? Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 and 10 live yor other traumafic event, the Medical Examiner must be not a withly or other traumafic event, the Medical Examiner must be not ongwood Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nFaut 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta 19a, Informant's Name/Relationship (Type, Print) Marka Lykeshix Turne
Oa. Method of Disposition 16 ND 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 9-1215 Stricker Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine for use as the burial-Division or Vital Records, P.O. Box 68760, signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2000 1☐ Yes 2 No 1 Tyes To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1XInpatient 2 ER/Outpatient 3□ DOA ß 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 X Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene St. Baltimure 31. Date filed (Month, Day, Year) 32. Registrar Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Ella Lavena Testerman November 13, 2007 11:59 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 134 East Pennsylvania Avenue Harford Bel Air If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 □ M 2 □ X I July 29, 1949 Virginia Director 216-52-8793 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 'natural", or Items 23a or 28a-f shov dical Examiner must be notifiled at 1X Yes 2 □ No Director Maryland | Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 134 East Pennsylvania 21014 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 27 Is marked other than "natural traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrical Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Gordon Clyde (unk) Ball Mason 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Kristen L. Testerman / Daughter 134 E. Pennsylvania Ave., Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air, Maryland Bel Air Memorial Grdn 11-17-07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Juneral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MYOCARDEAL minutes **Physician** ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (unas a consequence of) Examine burial-transit and Due to (or as a consequence of) Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Director: within 24 hours at To the Funeral C completely filled i

Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANGEZO

6 ☐ Could not be

NOV 2 1 2007

3□ Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

S. ATWOOD Rd, BEL ATT IND 21014 1#205

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

32 Registrar's Signature

and manner stated.

1 ☐ Yes 2 ☐ No

D0056607

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)
November 15th 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 00 Date of Death Month . Decedent's Name (First, Middle, Last) Day Year **Physician** 1:30 AM 19, 2007 November Emma B. Wilson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collingswood Nursing & Rehabilation ¢tr. Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1 ☐ M 2 🗷 F 101 07/04/1906 Delaware Director 221-07-9778 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 Yes 2 No Director Rockville MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or United States 20851-Pages 1 and 2 should be filed within 72 hours after death Funeral 13202 Okinawa Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. "natural", or Items 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify. ģ 3 M Widowed 4 □ Divorced Completed er than "natur, the Medical E 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Own Home College (1-4or 5+) Elementary/Secondary (0-12) Homemaker other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nt of Health and Mental H If item 27 Is marked oth or other traumatic even Be Martha Elizabeth Donovan Wallace Andrie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13202 Okinawa Ave. Rockville, MD 20851-Carolyn W. Pooley/Daughter permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Nov 20 1 ☐ Burial 2 Ma Cremation 3 ☐ Removal from State Beltsville, Maryland 2007 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Ser MU038Z Rapp Funeral & Cremation Services Silver Spring, Maryland 20910-933 Gist Ave. sprincer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rrythmia /Medical Due to (or as a consequence of): Examiner oronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Division or Vital Records, P.O. Box 68760, & attending physician and for use as the burial-trar Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth Day Year Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9□Unknown 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 12 No has certificate 1□ 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 after death. in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler

12

State Registrar ELS 11441 97/5 (Year) 32. Head tar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

Modificate Dr. Rockville, MD 20850

Doc 62435

		-	L State	State of Maryland /	Department of Health Certificate of Death		giene Reg. N2 0 0 7	37291
	Physicia		1. Decedent's Name (First, Middle, Last) Ruth		Wells	2. Date of De Month		3. Time of Death 8:30 A M
	/Medic Examin Funeral	er	4a. Facility Name (If not institution, give single fracture Care) 5. Social Security Number 6. Sex	reet and number) The Canton H 7. Age (in yrs. last b) M 2015	4b. City, Town, or Location Af. If Under 1 Year If Under 1 Year Hours Months Days Hours	of Death I MO C r 24 Hrs. 8. Date of Bir Min. Month, Da	4c. County of Death	nplace (State or Foreign
L.	Director		213-05-5451 Usual Residence of Decedent 10a. State 10b. County	72	Yrs. who or Location	Junes	27, 1915 M	10d. Inside City Limits
	the Maryla 28e-f ehov	rector	Mary Jan D 10e, Street and Number		Altimore 10f. Zip Code		10g. Citizen of What Co	Yes 2 No
336	be filed within 72 hours after death with the Maryland at Hygiene. A control of other than "neturel", or items 23e or 28e-f ehow dother than "neturel", or item mat be notified at event, it a Maxical Examitration at the notified at	by Funeral Director	1360 S. Ellu	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	13. Was Decedent of Hispanic On If Yes, specify Cuban, Mexical 1 Yes 2 No Specify	rigin? (Specify Yes or No an, Puerto Rican, etc.)	14. Race - Ame Black, White	
21215-0036	d within 72 hou giene. er then "neture i the Mudical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		Sa. Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired) COIN Room O	perater		Industry NAL BANK
aryland	d d d d	To Be C	17. Father's Name (First, Middle, Last)	Pastertie	ld C.	ner's Name (First, Middle Ather I we	CAle	++
altimore, M	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke eny Injury or other treumatic. 2002.		19a. Informant's Name/Relationship (Tyr. 20a. Method of Disposition 1	NNOCK - 20b. Place come Green	9b. Mailing Address (Street and Num 3513 F. FA of Disposition (Name of tery, crematory or other place) 22. Name and Address of Fac 1056ph M. 2 2635 Contle	yette St	· Balto L	1021224
Fnysician /Medical Examiner	cal Examiner	23a. Part1. Enter the disease, or compliance, or heart failure/ List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	o not enter the mode of dying, such a content of the mode of dying, such a content of the mode of dying, such a content of the mode of dying, such a content of the mode of dying, such a content of the mode of dying, such a content of the mode of dying, such a content of the mode of dying, such a content of the mode of dying, such a content of the mode of dying, such a content of the mode of dying, such a content of the mode of dying, such a content of the mode of dying, such a content of the mode of dying, such a content of the mode of dying, such a content of the mode of dying, such a content of the mode of dying, such a content of the mode of dying, such a content of the mode of dying and the content of the mode of the mode of the content of the mode of dying and the content of the mode of the content o	is cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death	
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal dec 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 Ectopic pregnancy		23d. Date of de Month	livery Day Year
a	uires that the signed by the detaction	by	Part II. Other significant conditions con	tributing to death but not resultin	g in the underlying cause given in Par		tobacco use contribute to	the cause of death?
of Vital Records,	The law requate has been page 2 shou	Completed				24a. Wa auto peri 1 🗆 Yes	opsy prior to death?	utopsy findings available completion of cause of
ion of Vita	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation		0.1	28d. Describe	one) sidence 6 Other (Spe	acify)
Division	el or Attences after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office		(Street and Number or Rown, State)	ural Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical (29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Examination	sician: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death occurred at the time, date and/or investigation, in my opinion, d	and place, and due to the eath occurred at the time	e, date and place, and du	e to the cause(s)
D	To the within To the comp	Me	29b. Signature and title of certifier)	29c. License numbe 1) 4 > 4		29d. Date signed (Mon	th, Day, Year)
		ate	30. Name and address of person who co	4 3 5	UT OSLICA DI	HIVE TO	wlon w	np 21204

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 4:13a M <u>liams</u> 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frank forc Nursing Home timore Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number Age (In yrs. last birthday) **Funeral** Year) Months 1 M 2 White Director 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 1 Tres 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 12. Was Decedent Ever in U.S. Armed Forces? 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 300 by Funeral American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Action 4 19a. Informant's Name/Relationship, (Type. Print) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 04 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat re of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. dying, such as cardiac or respiratory Immediate Cause (Final **Physician** Coronar disease or condition resulting in death) /Medical Due to (or as a convequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9□Unknown 9 I I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 2 No On 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 12 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mariner as states. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier rivehru himi 30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Mirebrahimi, MD

2007

NOV

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, MD 2120

N. Eutaw Street

32. Registrar's Signature

riedse	Type or Print in Black Indelible Ink. Ensure All Copies A	\re Legible.
For State Registrar	State of Maryland / Department of Health and Mental Hygi Certificate of Death Re	iene _{99. No} 2
Decedent's Name (First, Middle, Last	2. Date of Death Month	a. Time of Death
Tyrone We	ndle Wallace NON	Day Year 16 2007 06.45 AM
4a. Facility Name (If not institution, give	ve street and number) 4b. City, Town, or Location of Death	4c. County of Death
GOOD SAMARIT		
212-48-8188	Months Days Hours Min. (Month, Day,	Year) 9. Birthplace (State or Foreign Country) MD
Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
WD	Baltimre.	1 ☐ res 2 ☐ No
10e. Street and Number	10f. Zip Code 10	Og. Citizen of What Country?
1918 Worth	ourne Avenue a1239	U.S. A
11. Marital Status	12. Was Decedent Ever in U.S. Armed Porces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married	1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:	Specify: Olack
3 ☐ Widowed 4 ☑ Divorced	Year or Dates:	BIACK
15. Decedent's Ec (Specify only highest gra	ade completed) (Give kind of work done during most of working	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	Zilly City Elm Many
17. Father's Name (First, Middle, Last)		Balto. City Fire Depart. Maiden Surname)
Mosley Mallor	A LANG BOOK	9
19a, Informant's Name/Relationship ((Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number,	City or Town, State, Zip Code)
Via Hinto A	arghter 120 Yorkshire Terrace Hampt	
20a. Method of Disposition		20c. Location - City or Town, State
1 Burial 2 □ Cremation 3 □	Removal from State cemetery, crematory or other place)	
4 ☐ Donation 5 ☐ Other (Specif		Anliner AAN
21. Signature of Funeral Service Licen	insee 22. Name and Address of Facility	Altimore MD
21. Signature of Funeral Service Licer	ensee 22. Name and Address of Facility Vougno C.	
leen W.	4905 York Magd Baltimore	MD alala Approximate
23a. Part1. Enter the disease, or com shock, or heart failure. List only	nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrevone cause on each line.	MD BIZIZ
23a. Part 1. Enter the disease, or com	nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrevals. $SEPSIS$	Approximate Interval Between
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Examiner Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit by Physician/Medical Be Completed Certification: To

TYRONE

WALLACE,

Physician /Medical **Examiner**

> IF FEMALE: 23b. Was dece 1 ☐ Yes 9 ☐ Unkr Part II. Other s AST 25. Was case examiner? 1 Tyes 27. Manner of 1 Natura 2 ☐ Accide 3 Suicid 4 Homic 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier

Director

Completed by Funeral

To Be

Physician

Funeral

Director

/Medical Examiner

> 29c. License number M.D

29d. Date signed (Month, Day, Year)

RES-000

NOV 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZUBAIR SHAIKH, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239

State Registrar

5

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State	of Marylar	nd / Depa <i>Cer</i>	artmen <i>tificat</i>	t of H e <i>of L</i>	ealth and N Death	Mental H	ygiene Reg. No.	2007	1 37294	
Physi	cian	1. Decedent's Name (First, Midd							2. Date of D Month	eath Day		NA NA	
/Med Exam		Ruby Kathle 4a. Facility Name (If not institution				4b. City,	Town, or	Location of Death		November 19, 2007 2:			
Funera Directo		Jacob's Well 5. Social Security Number 236-26-4516	Assisted 6. Sex 1 M 2 XF	Living 7. Age (In yrs. 92	last birthday) Yrs.	If Under Months		Air If Under 24 Hrs. Hours Min.	8. Date of B	ay, Year)	Harfo 9.8 15 We	ord Country) est Virginia	
death with the Maryland me 23a or 28a-f show rinust be notified at	tor	Usual Residence of Decedent 10a. State 10b. Count	y rford	10c. Ci	ty, Town or Lo	cation	11				10d. Inside City Limits 1 ☐ Yes 2 🔯 No		
or 28s	Director	10e. Street and Number			+ 010	10f. Zip	Code				zen of What (Country?	
	Funeral	1858 Beth Bri 11. Marital Status 1□ Never Married 2 Ma	12. Was De	cedent Ever in U Forces? 2 1 No	1	21050 Was Decedent of Hispanic Origin? (Specify Yes of Yes, specify Cuban, Mexican, Puerto Rican, etc 1 □ Yes 2♥ No Specify:			pecify Yes or No Rican, etc.)	10-	USA 14. Race - An Black, Wh Specify:	nerican Indian, nite, etc.	
4 12 13-0030 d within 72 hours after piene. r than "natural", or its tha Medical Examina	Completed by		ont's Education est grade completed	Dates:	16a Deced	lent's Usua	d Occupa		kıng		nd of Busines	White ss/Industry	
filed with Hygiene other tha		10		(1-401 3+)	H	omema	ker	18. Mother's Nan	na /Fires Adiddo		Own Ho	me	
	To Be	17. Father's Name (First, Middle George (unk)							(unk)				
Maryla d 2 should th and Men ty is marke traumatic	-	19a. Informant's Name/Relation	-		19b. Mailir	ng Address	(Street a	and Number or Ru	ral Route Num	ber, City o	r Town, State	, Zip Code)	
Heal Heal		Kathi Workman 20a. Method of Disposition 12 Burial 2 Cremation	3 □Removal fro	m State	Place of Dispo cemetery, crem	sition (Name	ne of ther plac	θ)	Date	20c. Lo	cation - City o	MD 21050 or Town, State	
그 원 원 분	5世と 4回Donation 5回Other (Specify) Green Hill Cemetery 11-23-07 IInion - U												
Physicial		23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition	st only one cause or	t caused the dea n each line.	th. Do not ent	er the mod	e of dyin	g, such as cardiad	or respiratory	arrest,		Approximate Interval Between Onset and Death OVER 2 May	
BOX 68/60, eath certificate be executed attending physician and for use as the burial-transit	_	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	quence of): O I WT? quence of): THEK quence of): TEX	215 1	718E		50/10	7		OVER 2 HOUSE OVER 2 HEARS			
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II RECORGS, P.O. The law requires that the rate has been signed by the page 2 should be detached.	Completed						-		24a. Whau pe	topsy rformed?	24b. Were prior to death		
r Vital F ysicien: Th is certificate director, pag	B	25. Was case referred to medic examiner?	Hospital		7500		Oth	26. Place of Dea			24301 (a	Acat Tirrir	
ng Ph Merth Merth	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Penc 2 Accident inves	28a. Da	☐ Inpatient 2 ☐ te of Injury onth, Day Year)	ER/Outpatier 28b. Time of Injury		28c. Injun Worl	4 🗆 Nursing r			idence 6夕Other <i>(Specify)</i> Asst.Livin how injury occurred		
DIVISIO ital or Attendi irs after death. ral Director: A	Certification:	4 Homicide	mined 28e. Pla	ce of Injury - At h Ilding, etc. (Spec	ify)				City or 1	own, State	·) 	Rural Route Number,	
To the Hospital of within 24 hours at To the Funeral D completely filled it	Medicai	29a. Certifier 1 Certify (Check only 2 Medical	ying Physician: To t al Examiner: On the and m	the best of my kn basis of examin anner stated.	owledge, deatl ation and/or in	h occurred vestigation	at the tin , in my o	ne, date and place pinion, death occu	e, and due to the urred at the tim	ne cause(s) e, date and	and manner I place, and d	as stated. due to the cause(s)	
To the within To the	₩ We	29b. Signature and title of certif		MOX			9c. License number 29d. Date signed (Mon			onth, Day, Year)			
i		30. Name and address of person			m 23a) (Type,	Print)	SP¢	6 16 3 89		NOVE	MGER	20, 2007	
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	State of Maryland / Department of Health and Mental Hygiene 2007 37295 Certificate of Death Reg. No.											
		Registrar 1. Decedent's Name (First, Middle, Last)		Cei	Tillicate of t	Death	2. Date of Dea	eg. No. th	3. Time of Death			
Physicia	ın	Victor Paul Will	necker				Month November	,	007 11:05 A ^M			
/Medic Examin	_	4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of				
	4	Stella Maris Hosp	oice	1. 11:46-4	Timo:		8, Date of Birth		imore Birthplace (State or Foreign			
Funeral		5. Social Security Number 6. Sex	M 2□F	s. last birthday) Yrs.	Months Days	Hours Min.	Apr. 1	, Year)	Country) Pennsylvania			
Director		181-18-8021 Usual Residence of Decedent	88				Hor. I	1919 1	_			
ryland show		10a. State 10b. County	10c. 0	City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐No			
he Ma 8a-f s	Director	Maryland Harfor	rd	Ab:	ingdon 10f. Zip Code		1	log. Citizen of Wha				
with t												
death ms 2: r mus	Funeral		on Road 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.			
after or ite	Fu	1 Never Married 2 Married	Specify:									
hours tural", al Exa	ed by	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busin	White ness/Industry			
nin 72 n "na' Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of work d)	ing					
d with giene er tha	Com	12			Machinis				ıfacturer			
be filed within 72 hours after death with the Maryland tlal Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)				
2 should and Men is marke aumatic	ဍ	Tudwig (unk) Will 19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street	Marie and Number or Rui	(unk) F al Route Numbe		ate, Zip Code)			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 6. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	. 2	Barbara Snyder / I				n Rd., Ak						
item		20a. Method of Disposition 1 Disposition 2 Cremation 3 F	201	Place of Dispo	osition (Name of matory or other pla		Date	20c. Location - Ci				
Pages ment of I	Ш	4 □ Donation 5 □ Other (Specify)	S S		's Cemete 2. Name and Addre		23-07	Altoona	, Pennsylvania			
permit. Departi Imports any Inj once.		21. ighature of Fwoeral Gervice Licens	-1 01000									
0.02 8 0		23a. Part 1. Enter the disease, or compl shock, or in art ailure. List only or	ications that caused the	th. Do not en	ter the mode of dying	ng, such as cardiac	or respiratory ar	con, Mary rest,	/land 21009 Approximate Interval Between			
Physician		Immediate Cause (Final							Onset and Death			
/Medical		disease or condition resulting in death)	Due to (or as a cons									
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bed is	nine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a cons	sequence or).								
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The law requires that the death certificate be ate has been signed by the attending physicis page 2 should be detached for use as the burners.	Physician/Medical	IF FEMALE:	20- 16					and Data	of dellicens			
attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pre 1□Live birth 2□F 4□Pregnant at time	etal death 3	☐Ectopic pregnanc	cy		23d. Date Mont				
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e faw nas be	Completed						24a, Was auto perfo	osy pri	ere autopsy findings available or to completion of cause of ath?			
sician: The certificate rector, pag		25. Was case referred to medical				26. Place of Dea	1□ Yes	2 X No 1	□Yes 2□No			
Physician: The far this certificate has al director, page 2	o Be	evaminer?	Hospital: 1 ☐ Inpatient	ER/Outpatie	ent 3 DOA Ot	hor			(Specify) HOSPICE			
ig Phy ter this	⊢	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time Injury		ury at ork?	28d. Describe	how injury occurre	d			
tendir eath. tor: Al	27. Manner of Death 1 X Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)											
or Att	riii.	4 Homicide determined	building, etc. (Sp		treet, factory, office		City or To		or flarar floate flameon,			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.												
he Ho in 24 h he Fu pletely	Medical	(Check only 2 Medical Exam	and manner stated.	nination and/or			med at the time					
To t To t	Σ	29b. Signature and title of certifier				Se number		,	(Month, Day, Year)			
1.		30. Name and address of person who o	completed cause of doeth	Item 23a) (Type		1)/61		11/1	7/67			
X		DR. TARIO MAHMOO				TIMONIUM	MD 210	193				
St	ate	31. Date filed (Month, Day, Year)	32 Registrar's S	ignature	aske		- 111					
Regist	rar	NOV 2 1 20	Ul per letters	20 1/2								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) $\overset{\text{Day}}{17}$, $20\overset{\text{Year}}{07}$ **Physician** November 5 AMBernice Τ. Westlein /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 413 Mercer Road Rockville If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Ye Sept. 16, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months Days Year China 1 □ M 2**X** F 81 212-68-3806 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 3a or 28a-f show t be notified at 10a. State 10b. County 1 X Yes 2 No Director Rockville Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 413 Mercer Road 20852 and Mental Hygiene.
Is marked other than "natural", or items 23a Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2**X** No Specify: White Baltimore, Maryland 21215-0036 Specify: þ 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Administrative Assistant Private School 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Chester Ronning Inga Rorem 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau 124 Cougar Trail, Winchester, Virginia 22602 Westlein/Daughter Ronnine M. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dec. 28, 1 X Burial 2 ☐ Cremation 3 □Removal from State Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 2007 21. Signature of Funeral Service License 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Rockville, Inc.
300 W. Montgomery Avenue, Rockville, Maryland 20850 Million M01173 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Gastric Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the chird Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ed by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2**X** No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2**▼** No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral (28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or To the Hospital within 24 hours at To the Funeral D I 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Har ho. November 19, 2007 8,10 205794 30. Name and addr - s of person who completed cau le of death (Item 23a) (Type, Print) Malgorzata E. Wojtowiczy M.D.8901 Wisconsin Avenue, Bethesda, Maryland

DHMH 17 Rev 1/2001

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death Dav **Physician** DEBBIE WASHINGTON NOVEMBER 16, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Towson Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 / 0 7 / 1 9 5 8 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 K F MARYLAND 212 84 1346 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD n/a BALTIMORE 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2733 EAST PRESTON STREET 21213 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc AFRICAN filed within 72 hours after Hygiene. 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2**X** No Specify: 2 3 ☐ Widowed 4 ☐ Divorced AMERICAN Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wind Department of Health and Mental Hygien. Important: If Item 27 is marked other that any injury or other traumating. TELEPHONE TELEPHONE CONSULTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES L. WASHINGTON G. WILLIAMS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN WASHINGTON/SISTER 9822 DECATUR ROAD BALTIMORE, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METRO CREMATORY 11/19/07 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun and Service Lio Insee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPTIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner INFECTED METASTATIC SARCOMA OF ABDOMEN if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine executed ding physician and se as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2. No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No nerat Director; / 2 Accident death 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11-16-0

State

Registrar

31. Date filed (Month, Day, Year) NOV 2 1

FRANCIS KHOO.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2007

32. gistrar's Signature

D30263

7601 OSLER DRIVE TOWSON, MARYLAND

Baltimore, Maryland 21215-0036

Division or Vital Records. P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death /Month Year **Physician** 7 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hoskins Timore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🗙 F 310.96.6220 38 **Director** 01-18-1969 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Md1 ☐ Yes 2 ☐ No Funeral Director Howard Clarksville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 12208 Summer Sky Path. 21029 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates; 1 Never Married Married Yes 2□No Specify: Mexican Baltimore, Maryland 21215-0036 þ Specify: Hispanic 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Care Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oliver Acevez Lucina Avitia ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William D. Yu -Husband 12208 Summer Sky Path.Clarksville, Md 21029 20a. Method of Disposition 20c. Location - City or Town, State 1 Removal from State Louis Cemetery 11/24/2007 4 Donation 5 Dother (Specify) Clarksville, Md 22. Name and Address of Facilit Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licenses MU1283 5555 Twin Knolls Rd.Columbia, Md 21045 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final **Physician** neumonia 3 Days disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9. Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2□No 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 200 No 1 npatient Certification: To 2 ER/Outpatient 3 DOA after death.
I Director: After this
d in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of bers in who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Hospital 600 N. Wolfe Street Baltimore Maryland Palle 31. Date filed (Worth, Day, Year) NOV 2 1 2007 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Michael J. Zborowski 18, 2007 2:30 P. November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Villa Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 XM 2 □ F 220-20-9739 Director 79 3, 1928 Nov. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 NYYes 2 □ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 240 East Medwick Garth 21228 Funeral USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. \$ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Computer Technician d 2 should be filed v th and Mental Hygie 7 Is marked other tl <u>US Government</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev Michael Zborowski Cecelia Stamborski 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Uldine Zborowski Wife 240 East Medwick Garth; Baltimore, MD 21228 ce of Disposition (Name of Date 20c. Location - City or Town, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cemetery 11/21/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Functal Service Licensee N21280 1630 Edmondson Avenue; Catonsville. 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** larcinoma, Metastic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Durito (cr.es a nonsequenno of) Examiner sician and burial-transit certificate be executed Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Vear 4☐Pregnant at time of death ed by the a 5 ☐ Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Venous thromboph/e 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1 Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospital or Attending 5 Pending investigation 1 Naturai death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

State Registrar

Medical

29a. Certifier

31. Date filed (Month, Day, NOV 2 1 2007 GRAHAM. 1001

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Hats

29d. Date signed (Month, Day, Year)

		_ For	State o	f Marylan	•	artment of H		Mental Hy	/giene		
		State Registrar			Cei	rtificate of	Death		Reg. No.	007	37300
Physicia	an	Decedent's Name (First, Middle	, Last)					2. Date of D	Day	Year	3. Time of Death
/Medic	al	Abdullahi	Ham		A1	dalla	at a select of Darel	Novem		2007	8: 10AM
Examin	er	4a. Facility Name (If not institution		,			r Location of Death	1		unty of Death	
Funeral		Doctor's Commun 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Lanham If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	ince Ge 9. Birthp	lace (State or Foreign
Director		218-19-8478	1 X M 2□F	76	Yrs.	Months Days	Hours Min.	JAN.	ay, rear) L , 1931	l Suda	
pu »		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation				1	0d. Inside City Limits
//aryla	ō									Ι.	1X□Yes 2□No
with the Marylanda or 28a-f show	rect	Maryland Princ 10e. Street and Number	e George'	s New	Carro	10f. Zip Code			10a. Citizen	of What Coun	itry?
death with the Maryland ms 23a or 28a-f show r must be notified at		7502 Riverdale	Road			20784			Sudar	1	
	Funeral Director	11. Marital Status		edent Ever in U.	.S. 13.\	Was Decedent of H	lispanic Origin? (S	pecify Yes or N	0- 14.	Race - Americ Black, White,	
after		1 Never Married 2 Marri	ed 1 ☐ Yes If Yes, Giv	2∭X No ve		1 □ Yes 2 🗓 No	Specify:			ecify:	
hours tural*	ed by	3 ☐ Widowed 4 ☐ Divorced	Year or D	ates:	16a Decer	dent's Usual Occup	nation			B1a of Business/Inc	
in 72 n "na fedic	olete	(Specify only highes	t grade completed)		(Give	kind of work done of NOT use retired	during most of wor d)	king	100. Kind C	or business/inc	lustry
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be filed within 72 hours after ital Hyglene. Id other than "natural", or ite event, the Medical Examine	Bec	17. Father's Name (First, Middle, I	Last)				18. Mother's Nan	ne (First, Middle	e, Maiden Sur	rname)	
ould b Ments arked atic e	P	Hamid Abdalla					Sitti Fa				
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa once.		19a, Informant's Name/Relationsh			19b. Mailir 7502	ng Address <i>(Street</i> Riverda Carrollt	and Number or Ru le Road	ıral Route Numi	ber, City or To	own, State, Zip	Code)
1 and Health em 27 ther t		Aicha Abdulghan 20a. Method of Disposition	i / Wife	20h F	New Place of Dispo	Carrollto	on, MD 20	0784 Date		on - City or To	
ages nt of l		1 X Burial 2 ☐ Cremation		State		sition (Name of matory or other plac	1 110 4	6,		,	
artme artme ortant injun	ŀ	4 ☐ Donation 5 ☐ Other (S _k 21. Signature of Funeral Service I		עוא	22	Mem. Park	ss of Facility			1, Mary	
permit Depar Impor any ir		Brigger	m:72	MO1.	508	Thibadeau 933 Gist	Mortuar	y Servi	ce. P.	A.	20910
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Physician		Immediate Cause (Final disease or condition	Me	Postor	50 /		1 Seas				Onset and Death
dical		resulting in death)	Due to	(or as a consequ	uence of):	-1	_				
Examiner		Sequentially list conditions,	b/	ver	+a	1/Wel	2				
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sician and burial-transit	xan	that initiated events resulting in death) Last	c	or as a consequ	uence of):	ario	, ,		7		<u> </u>
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tificati g phy as the			_ u				,		V		
death certific attending p	Physician/Me	IF FEMALE; 23b. Was decedent pregnant		come pf pregna		Ectopic pregnancy	,		23d.	. Date of delive	*
e dea he att	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of d		Other (specify)				Month	Day Year
d by t	Phy	9 ☐ Unknown Part II. Other significant condition			ulain na in Alban	- dankina aasaa ah	an in Dani I	aan Did	tobosso was		ne cause of death?
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requ been should	etec	,	1 0()			-					
ne law has l	Completed								s an 2 ppsy formed?_	4b. Were auto prior to cor death?	psy findings available mpletion of cause of
in: TI ificate or, pa	ပ္မ	25. Was case referred to medical					00 Plant of Page	1□ Yes	22No	1 ☐ Yes	2.☑ No
ysicie s cert direct	To Be	examiner?	Hospital:	npatient 2 🗆	ER/Outpatien	t 3 DOA Oth	er: 4 Nursing H	ome 5 ☐ Res		Other (Specifi	w)
ig Phr ter thi		27. Manner of Death	28a. Date		28b. Time of Injury	28c. Injur Worl		28d. Describe			/
endir sath. or: Af he fur	atio	1 Natural 5 Pending 2 Accident investig	ation	, 54, 754.7	,,		Yes 2 □ No				
or Att ter de virect n by t	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	and Zoe, Flace	of injury - At ho ng, etc. (Specif	ome, farm, stre	eet, factory, office			(Street and N own, State)	umber or Rura	l Route Number,
pital curs af		00- 0-differ d Mantiferin	Physiology To the	heat of multima	udoden de di						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying (Check only one)	g Physiclan: To the Examiner: On the b and man	asis of examina ner stated.	tion and/or in	vestigation, in my c	me, date and place opinion, death occu	e, and due to the irred at the time	e cause(s) and e, date and pla	d manner as si ace, and due to	tated. the cause(s)
ro the forther complete comple	Me	29b. Signature and title of confier	1			29c. Licens	e number		29d. Date si	igned (Moglith,	Day, Year)
7		1 The Trees	uf, 1	10		ATX	2446		11/0	5/2	007
	-	30. Name and address of person v	vho completed caus	e of death (Item	23a) (Type,	Print)	110			-/ 5	- /
		Kovalchuk	vadeliz	da, M	D 8118	Good Lu	ick Rd.	Lach	am, m	12,20	706
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Pau1a Burgos Vda. de Aquino 2, 2007 Nov. 23:10p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🙀 F Director 216-21-6007 80 06/30/1927 El Salvador Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notified at Director Prince Georges Capitol Heights 1 Yes 2 No Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be 7006 Central Avenue 20743 El Salvador Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 DXYes 2 □ No Specify: Salvadoran Completed by 3 X Widowed 4 ☐ Divorced Year or Dates Item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Self-Employed Elementary/Secondary (0-12) College (1-4or 5+) House Wife 2nd permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Coronado Burgos Agustina Cruz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Capitol Heights, Md. 20743 Ana Lilian Aquino (Daughter) 7006 Central Ave., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State La Libertad, Family Cemetery 11/11/2007 4 Donation 5 DOther (Specify) El Salvador 21. Signature of Funeral Service Licenses 22. Name and Address of Facility H. Bacon Funeral Home, 7 14th Street, NW Wash Inc. 3447 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Washington, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseque **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Dav Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1□Yes 2□No the detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing an death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 【☐ No 24a. Was an certificate has autopsy performed? 1∐ Yes 2X No or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

31. Date filed (Month, Day NOV 0 6

29b. Signature and title of certifier

7701 Carroll Ave., Nasreen Kango, M.D. 32. Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

Takoma Park, Md. 20912

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 State Registrar Amend 28b, perME, g874, 12/3/07 TT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 3, 2007 Physician Robert Scott Ackerman a^{M} 8:55 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles 6975 Rose Lane LaPlata If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral X**□ M 2□ F Vrs 212-76-0425 May 27,1960 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 ☐ Yes 2 🔀 No Director Maryland Charles LaPlata 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or "natural", or items 23a 6975 Rose Lane 20646 U.S.A. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 → Yes 2 → No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1979-1 ☐ Yes 2 ☐ No Specify. Specify: White Completed by 3 Widowed 4 Divorced 1983 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ed other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Water Treatment Operator Charles Co. Gov. 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Carol Barron ၉ Harry Ackerman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6975 Rose Lane, LaPlata, Md. 20646 Wife Gail Ackerman 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 8,2007
Maryland Veterans Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cheltenham, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licens 21. Signature of Funeral Service Licenses 220640

M00668 Williams Funeral Home, P.A. 20640

Md

Approximate Interval Between Onset and Death

Approximate Interval Between Onset and Death

Approximate Interval Between Onset and Death

Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Gun Shut Wound disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, leave. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-tran Due to (or as a consequence of): Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached a□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has e 2 certificate has rector, page 2 1∐ Yes 20 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28b. Time of unk. After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Gun Shed would to the her 1 ☐ Yes 2 ☑ No 8:55 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) at home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6975 Rose Local 3 Suicide 4 ☐ Homicide at

death certificate be executed Box 68760. Ö ₫. or Vital Records. Division

death with

72 hours after

filed within

Maryland 21215-0036

Baltimore,

or Attending

the Funeral Director: npletely filled in by the hours Medical within 24

29a. Certifier

(Check only one)

29b. Signature and title of certifier

State Registrar

w. Tayouin

29c. License number D0050883 Lu

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

NOV. 6. 2007

pluta, MD, charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PL plata MD 1/655 WINESUP La

and manner stated.

31. Date filed (Month, Day, Year) NOV 0 6 2007

07-08763	
Olin Wesley Briggs	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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	1- For State Certificate of Death Reg. No.										
Physicia edical Exami	ın/	1. Decedent's Name (First, Middle,Last) Olin Wesley Briggs, Jr.			Date of Death Worth Day Vear Vovember 11, 2007 3. Time of Death 0750 hrs						
K.		4a. Facility Name (if not institution, give street and number) 802 Gardens Court	4b. City, Town, or Location of Death Federalsburg		4c. County of Death Caroline						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.		M/DD/YYYY) 9. Birthplace (State or						
Director		220-52-0430 _{1\bigmax M} _{2\bigmax F} 55 y	rs. Months Days Hours Min.	12/25/	51 Foreign MD						
>		Usual Residence of Decedent			10d. Inside City Limits						
ow any		10a. State 10b. County 10c. City, Town or Loc Fe	deralsburg		1 Yes 2 X No						
e Maryland or 28a-f show	ç	MD Caroline 10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?						
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	226 Sullivans Mill Road	21632	Un	ited States						
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72 hours after death n "natural", or iter al Examiner must	Funeral	1 Yes 2 No	Plack								
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0036 within 72 iene. er than Medical	Completed	12	stic Production		lastic Manufacturing						
11215-0036 Id be filed within 72 hou fental Hygiene. narked other than "nat event, the Medical Exa	Be Co	17. Father's Name (First, Middle, Last) Olin Wesley Briggs, Sr.	(First, Middle, Maid ene Johi								
		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	r, City or Town, State, Zip Code)								
MD d 2 sho lth and n 27 is			er, MA 02124								
ages I and 2 shount of Health and It: If item 27 is rother traumatic		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State crematory or		Oc. Location - City or Town, State							
Baltimore, permit. Pages I an Department of Her Important: If ite injury or other tr		4 Donation 5 Other Specify: Federal									
Bal permi Depar Impo injur		21. Signature of Funeral Service Licensee	Name and Address of Facility Fra 216 N. Main St., F	mptom fur 'ederalsbu	irg, MD 21632						
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not ente failure. List only one cause on each line.	shock, or heart Approximate Interval Between Onset and								
/Medical		Immediate Cause (Final disease a. Complications of alcoho	1 abuse		Death						
		or condition resulting in death) Due to (or as a consequence of):									
	ner	Sequentially list conditions, if any, leading to immediate couse. Enter Underlying Couse									
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and and transit		d									
O, e be ex rsician burial	n/Medical	X UNPENDED X AMENDED 27, perME, g873, 1	1/29/07 TT								
876 tificate ng phy as the	M/m	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth	Fetal death 3 Ectopic pregna	ancy	23d. Date of delivery Month Day Year						
Box 68760, e death certificate be er the attending physician ed for use as the burial	Physicia	1 Voc 2 No 0 Hokeave	Other (Specify)								
Ç € 2°€	Phy	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?						
ords, P.C. w requires that is been signed is	d by			1 Yes	2 No 3 Probably 4 V Unknown						
ords v requi s been	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of						
Recol	omo			performe 1 Yes 2	death? No 1 Yes 2 No						
	BeC	25. Was case referred to medical examiner?	26.Place of Death (Check								
of Vital Records, ng Physician: The law require the this certificate has been simeral director, page 2 should t											
nding nding tth.	ion:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. trijury at Work? 1 Yes 2 No									
Division tal or Attendi rs after death. al Director: /	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	eet and Number or Rural Route Number, City								
E 6 2	Certification: To	4 Homicide determined (Specify)	e)								
E 2 7 5		To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
To the within 2 To the complet	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
		J. M. L	O.C.M.E.	1	November 12, 2007						
		30. Name and address of person who completed cause of death (Item 23a)	Name Of the of Tables and Care	1204							
(211)	ate		Penn Street, Baltimore, MD 2	1201							
Regis	1101/0 1 788/ 12/5 c // Williams										

Butler

			Plea	se Type or Prin					•	_	ble.			
		·	For State Registrar		aryland / I		rtificate of	lealth and N Death	R	eg. No. 2	107	37305		
	Physici /Medi		Decedent's Name (First, Middle CHARLOTTE	BRYAN					2. Date of Dea Month OCTOBER	21 2	Year 2007	3. Time of Death 7:00 PM ^M		
20.	Examir	ner	4a. Facility Name (If not institution RAYLAND ACRE	S	o (In um loot hi	inth do. d	4b. City, Town, o TRAPP If Under 1 Year	r Location of Death E T If Under 24 Hrs.	8. Date of Birth		4c. County of Death TALBOT			
Ü	Funeral Director		5. Social Security Number 216-18-2883 Usual Residence of Decedent	6. Sex 7. Ag 1 □ M 2 🛣 F	e (In yrs. last bi 87	Yrs.	Months Days	Hours Min.	AUG 4, 1	Year)	9. Birthplace (State or Foreign Country) VIRGINIA			
	Maryland f show ied at													
	3a or 28a st be notif	I Director	10e. Street and Number 29140 KRISMORI	E CT.			10f. Zip Code	673	1	0g. Citizen of	What Cour	itry?		
036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show may Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? ied 1 □ Yes 2 🕅			Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Ra Bla Speci	ce - Americ ack, White,			
Baltimore, Maryland 21215-0036	thin 72 hore. e. an "natur. Medical E	Completed		t's Education st grade completed) College (1-4or 5		(Give life.	DO NOT use retired	during most of work	king	16b. Kind of E				
d 21	filed wif Hygien ther th		9 17. Father's Name (<i>First, Middle</i> ,	0		HOM	IEMAKER	18. Mother's Nam	ne (First, Middle,		N HOM	[E		
/lan	uld be wental	To Be	WALTER LONG						E BAKER					
Mary	d 2 sho th end I 7 Is ma trauma	ľ	19a. Informant's Name/Relations		1			and Number or Ru POINT RI				Code)		
re, l	ss 1 and of Heall item 2		SHARON DAFFIN/I		20b. Place of	of Dispo	esition (Name of matory or other place	i	Date	20c. Location		own, State		
timo	t. Pege tment c tant: If		1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	Specify)	1	RD (CEMETERY	10/2	26/2007	OXFORI				
Ba	Depermine Depermine Imported Fig. 12. Conce.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL F 200 S. HARRISON ST EASTON, MD 21601											
	Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition												
	/Medical Examiner	_		b	a consequence									
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C										
68760,	rate be executed thysician and the burial-transit		resulting in death) Last	Due to (or as	a consequence	of):								
P.O. Box 6	The law requires that the death certificate be the lass been signed by the attending physic page 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknowg	23c. If yes, outcome 1 □Live birth 4 □Pregnant a 9 □ Unknown	2 Fetal deat		⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у			ate of deliv	ery Day Year		
ds, P	w requires that the debeen signed by the should be detached	by	Part II. Other significant conditions of the significant condition	1	out not resulting	in the u	nderlying cause giv	ven in Part I.	23e. Did to			he cause of death?		
or Vital Records,	The law rectate has been page 2 shou	Completed	Memie						24a. Was autop	rified?	death?	opsy findings available impletion of cause of		
/ital		Be Co	25. Was case referred to medica examiner?					26. Place of Dea	1∏ Yes ath (Check only o	ne)	1 □ Yes	2 No		
o	S S I	은	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpati 28a. Date of Inju	ıry 28b.	. Time o	" JUDOY		lome 5 Resid			ASSISTED LIVING		
27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred														
Divi	al or At s after d al Direct ed in by	Sertifi	4 Homicide determ	nined 28e. Place of in	ury - At home, t tc. <i>(Specify)</i>	farm, st	reet, factory, office		28f. Location (S City or Тои		nber or Run	al Route Number,		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	ledical (29a. Certifier 1 Certifyli (Check only one) 2 Medical	ng Physician: To the best Examiner: On the basis of and manner si	of examination a	ge, deat and/or ir	th occurred at the to	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and r date and place	nanner as s	stated. to the cause(s)		
	To the within 7	Me	29b. Signature and title of certifie	er UNV	M.C)	29c, Licens			29d. Date sign	red (Month,	Day, Year)		
	5		30. Name and address of person	who completed cause of o	death (Item 23a)	(Type,	Print) Fyrn	61822 St. Con	nbridge,	MO	461	5		
	St	ate	31. Date filed (Month, Day, Year, 00, 2, 3, 2007)		rar's Signature		•		<u> </u>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 WALTER F. BRUNNER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Eastor F.aston Talho remoria Hospita at If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth **Funeral** 1 XM 2 ☐ F Months Days Hours 19 1925 AUG 82 Director 059-20-5078 **NEW YORK** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD TALBOT OXFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21654 USA items 23a 27781 LITTLE OTWELL ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 'natural', or 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify. Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. Iem 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) TELEPHONE SUPERVISOR 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WALTER F. BRUNNER ROSALIE ST. HILL 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 27781 LITTLE OTWELL ROAD, OXFORD, MARYLAND 21654 JOSEPHINE BRUNNER/WIFE Department of Heal 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CEDAR GROVE CEMETERY 11/05/2007 4 Donation 5 Dother (Specify) PATCHOGUE, NY 21. Signature of Funeral Service Licenses anyl FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA USTROWSK. losoph 200 S. HARRISON ST EASTON, MD 21601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumoni days /Medical Due to (or as a consequence of) **Examiner** rebrovasa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Examiner The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ector, page certificate 2 No 2 X No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) **1**0 1 ☐ Yes 2 No 1 🔁 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GTVA

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Brunner

State Registrar 31. Date filed (Month, Day, Year)
NOV 0 2

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Stata FH TCDH 11/02/07 pha
Decedent's Name (First, Middle, Last) Certificate of Death Reg. N& UU 2. Date of Death 3. Time of Death 12.04A.M. Physician **Physician** Month 10 26 2007 Kemp Brown /Medical Leslie Kemp Brown 4a. Facility Name (If not institution, give street and number) 0004 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis <u>Anne Arundel</u> 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12-29-1927 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F Director 79 Md. 220-22-7908 Usual Residence of Deceder with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or Items 23a or 28a-f show The Medical Examinar must be notified at 1 Yes 2 No Directo Md. Oueen Annes Chester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14. Race - American Indian, White, etc. death v 216 Barren Ridge Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Iten any injury or other traumatic event, the Medical Examinar Once. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seafood 12 Waterman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernest Brown Ada Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence 216 Parren Ridge Rd., Chester, Md. 21619

Date 20c. Location - City or Town, State Brown/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition /07/07 -05-07 1 Burial 2 Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Md. Veterans Cem. Hurlock, md. 31. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover Street, Easton, Md. 21601 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Massive aspiration Priysician leveral minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ementio 1 Yes 2 No 3 Probably 4 Unknown peeu: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Coronary arte page 2 s autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; E 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

TVA

State Registrar 31. Date filed (Month, Day, Year) 200

onick M.D. 115 Sallitt Drive, Suite E

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

October 30, 2007

Stevensville, MD 21666

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** NOVEMber 07, 2007 0310 GEORGE SELDEN BRIGGS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner EASTON TALBO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Year Days 1**X** M 2□ F DEC. 14,1910 INDIA Director 96 146-12-1774 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1X Yes 2 No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be r 21601 **USA** 700 PORT ST., COTTAGE 200 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) AUDIO/VIDEO Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING CHEMIST 4 permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygie Important: If item 27 is marked other 1 any Injury or other traumatic event, <u>th</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY HART GEORGE W. BRIGGS ဂ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 PORT ST., COTTAGE 200 EASTON, MD 21601 JANE BRIGGS/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 11/8/2007 STEVENSVILLE, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 S. HARRISON ST. EASTON, MD 21601 HELFENBEIN & NEWNAM FUNERAL HOME PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONO /Medical Due to (or as a consequence of Examiner MILLO if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Resa burial-tran Due to (or as a consequence of) physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performed? Yes 2 2 No 1□ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D

certificate be executed Box 68760, P.O. Records, Division or Vital

Baltimore, Máryland 21215-003

State Registrar 29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 0 8 2007

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

710

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

and manner stated.

death.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend taite on Ma Manna hoe and mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav , Bartlett Year **Physician** Cynthia, 12:50 AM OCT 18 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Manyland Medical Center NIA Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

MAY 16,1932 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Hours 1□M 2 F Days CONNECTICUT 75 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 10b. County 1 □ Yes 2 No Director EASTON MD TALBOT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code iral", or items 23a or Examiner must be r 21601 USA 27781 LE GATES COVE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify Specify: WHITE Completed by **X** Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANNA ELIZABETH HANCOCK WILLIAM AYMER EBBETS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 S. HARRISON ST., EASTON, MD 21601 CYNTHIA M. BARTLETT/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important; If its any injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 10/19/2007 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST., EASTON, MD 21601 21. Signature of Funeral Service Licenses C.S.S.P. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** day Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 2X No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1X Inpatient 28b. Time of the funeral 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

22 South Greene Street, Baltimore MD 21201 Wermine Ashley 31. Date filed (Month, Day, Aegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

15

29c. License number

145 7481947

29d. Date signed (Month, Day, Year)

Oct 18 2007

Box 68760. P.0. Division or Vital Records,

Maryland 21215-0036

Baltimore,

To the Hospital or Attending the Funeral Director: Af the

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month Day)

egistrar's Signature

30 Name and eddress of person who completed cause of death (Item 23a) (Type, Print)
Robert Gold, MD 15225 Shady Grove Road, #201 , Rockville, MD 20853

and manner stated.

2007

Registrar

State

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D29300

29d. Date signed (Month, Day, Year)

November 5, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BENNING **Physician** 3 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mandrin House Harwood Anne Arundel 8. Date of Birth (Month, Day, Sept. 12, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Worth Carolina 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** Days Months Hours 1 🗌 M 90 222-16-5134 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show th and Mental Hygiene. ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notiffied at 1 □Yes 2KINo Director Maryland Anne Arundel Odentan 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 7616 Vulpe Court 21113 USA Pages 1 and 2 should be filed within 72 hours after death Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐ Yes 2 🕱 No f Yes, Give ⁄ear or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🗓 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amos Horne Creecy Cobb ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Lyons/Daughter 7616 Vulpe Court, Odenton, MD 21113 Health a Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. 7. MD National Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2007 Taurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 6 /Medical Due to (or as a onsequency **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Physician/Medical Examiner burial-trar Due to (or as a consequence of): the IF FEMALE If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗹 No Month Vear Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 TYes 2 No 3 Probably 4 Unknown Was a autopsy performed? 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 ∐ Yes 2 No 1□ Yes 25. Was case referred to medical examiner? funeral director, MANDRIN 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred HOUSE 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, thours after death.

-uneral Director: Af
ely filled in by the ful in 24 hours the Funeral Directory and filled in by

Certification: To Medical

29a. Certifier (Check only 29b Signature and title of

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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2007

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type Print) egistrar's Signature Day,

To the I within 2.

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certi-

DUTCHMAN'S LANG 610 egistrar's Signature

M

30. Name and address of person who mpleted cause of death (Item 23a) (Type Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 21 **Physician** VIRGINIA TYLER CHILTON OCTOBER 2007 2:35AMM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WILLIAM HILL MANOR EASTON TALBOT 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 7 F Days 95 Director 409-52-0067 JULY 4, 1912 ALABÁMA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 DUTCHMANS LANE 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify. þ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) HOMEMAKER OWN HOME permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othu any lijury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILSON GURLEY TYLER RUBY CLAYTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM CHILTON/SON 214 WYE AVE., EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 10/23/2007 STEVENSVILLE, MD 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUENRAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 21. Signature of Funeral Service Licenses or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disease, or com-shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Z4 km /Medical Due to (or as a conseq -nce of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-trar Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the a 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tous de 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐ Yes 2 ☐ No 1∐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM H. WOOD, JR. M.D. 501 DUTCHMANS LANE EASTON, MD 21601 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2 4 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** John Freas Clarke October 31, 9:30 рМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Olney Montgomery 8. Date of Birth (Month, Day, Ye Dec. 16, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year) 1925 **Funeral** Months 1**1** M 2□ F Maryland 215-20-3192 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits Director 1 ☐Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? De e ns 23a c must b \$127 Beckenham Court 20906 USA Funeral rai", or items ? Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 "naturai", or 1 ☐ Yes 2 No δ Specify: 3 Widowed 4 Divorced White Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Bureau of Engraving Elementary/Secondary (0-12) College (1-4or 5+) Master Plumber and Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic ever Albert Byard Clarke Katie Elizabeth Freas f Health and N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita L. Clarke/Wife 5933 Griffith Road, Laytonsville, MD 20882 other 1 Date 5, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov. permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 Alexandria, Virginia 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. Val 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Extensive-Stage Small Cell Lung Cancer Less than l month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transii Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. ☐Yes 2☐No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed page certificate 1 Yes 2 No To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3EXNo ဥ 1 🙀 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) COL D42452 November 5, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chitra Rajagopal, 18111 Prince Philip Drive, Olney, MD 20832 MD

State

Registrar

31. Date filed (Month, Day, Year)

06

2007

32. Refistrar's Signature

State Registrar

DHMH 17 Rev 1/2001

ALEXION

3110

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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Silver Spring

2007

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Lilian E. Cook						2. Date of D	eath		
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Laurel Regional Hospital Security Secu					4b. City, Town, or Location of I	Death	4c. Co	ounty of Death	
183-22-0241 10.0 County		Examin		Laurel Regional Hospital	Laurel				
The state of the s		Funeral			Months Days Hours	Min (Month, D	av, Year)	9. Birthp Coul	place (State or Foreign ntry)
Too. States Too. Country Too. Country States Too. Country States Too. Country States Too. Country States Too. Country Too. Country States Too. Country		Director		183-22-0241 84	rs.	April	14, 19	23 Penr	nsylvania
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Comparison of process dome during most of working Contract C	<u> </u>	ural", I Exa	db	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Decedent's Heuri Occupation		16b Kind		
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Approximate Calcage (Final Control C	ary	shou s mai							p Code)
Resurrection Cemetery; Nov. 8, 2007 Clinton, MD 22 Summar and address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 Physician Modelet Examiner Physician Modelet Examiner For the disease by complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Coronary Artery Disease Sequentially in cleaning and each line. Coronary Artery Disease Sequentially in cleaning and each line. Coronary Artery Disease Sequentially in cleaning and each line. Coronary Artery Disease Sequentially in cleaning and each line. Coronary Artery Disease Sequentially in cleaning and each line. Due to (or as a consequence of): Due to (or as		and 2 salth a n 27 l		000-80			-		0
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Physician Medical Examiner The proposed of the properties of the	a a a	ermit lepart nport ny ln nce,		21. Signature of Funeral Service Licensed					
Physician (Medical Examiner) Medical Examiner		<u> </u>		on Data They the disease of complications that squeed the death. Do r			.011, DC	Approximate	
Due to (or as a consequence of):			3 3	shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death		
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Due to (or as a consequence of): Comparison of the control of t			ē	Sequentially list conditions, Due to for as a consequence of	of);				
Due to (or as a consequence of): Comparison of the control of t		od d ansit	mir	cause. Enter Underlying Cause (Disease or injury that initiated events c.					
FEMALE: 230. Was decedent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1	Ö,	e exer lan ar ırial-tı	Exc	resulting in death) Last Due to (or as a consequence of	of):				
FEMALE: 230. Was decedent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1	876	ate be hysici	lica	d	· · · · · · · · · · · · · · · · · · ·			-	
Arterial Fibrillation 1 Yes 2 No 3 Probably 4x Unknown	မှ	ertific ling p	Mec	IF FEMALE: 220 If was outcome of pregnancy			25	Pd. Date of deli	ver/
Arterial Fibrillation 1 Yes 2 No 3 Probably 4x Unknown	80	attend for us	ian/	in the past 12 months?					
Arterial Fibrillation 1 Yes 2 No 3 Probably 4x Unknown	Ö	the de	ysic	1 Linknown	0				
25. Was case referred to medical examiner? Yes 25 No	٦.	that ted by	4	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Di	d tobacco us	e contribute to	the cause of death?
25. Was case referred to medical examiner? Yes 25 No	ds	quires n sign	d b	Arterial Fibrillation		1[]Yes 2□	JNo 3∏ Pro	obabły 4∑Unknown
25. Was case referred to medical examiner? Yes 25 No	8	w rec	ete					24b. Were au	topsy findings available
25. Was case referred to medical examiner? Yes 25 No	æ	The la	m o			pe	rformed?	death?	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil A. Meade 9811 Mallard Drive Laurel, MD 20708	ital	ian: 'rtifica				of Death (Check onl	y one)		
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil A. Meade 9811 Mallard Drive Laurel, MD 20708	r <	nysic nis ce direc		1 ☐ Yes 2X No Hospital: 1 X npatient 2 ☐ ER/Ou	itpatient 3 DOA 4 Nur				cify)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil A. Meade 9811 Mallard Drive Laurel, MD 20708	0 0	ng Pt fter tt ineral		(Ada-ath Day Vone)			e how injury	occurred	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil A. Meade 9811 Mallard Drive Laurel, MD 20708	Sio	tendl eath. tor; A	catio	Z Accident			(Street and	Number or Ru	ural Route Number
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil A. Meade 9811 Mallard Drive Laurel, MD 20708	\leq	or At ifter d Direct in by	ill.	determined 20e. Flace of Injury - Actionic, ic	ini, street, lactory, onice	City or	Town, State)	7,4,77,507 07 712	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil A. Meade 9811 Mallard Drive Laurel, MD 20708		spital ours a neral i		29a. Certifier 1 Certifying Physician: To the best of my knowledge	e, death occurred at the time, date and	d place, and due to t	he cause(s)	and manner as	stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil A. Meade 9811 Mallard Drive Laurel, MD 20708		e Hos 24 hr e Fur letely	dica	(Check only 2 Medical Examiner: On the basis of examination ar	nd/or investigation, in my opinion, deat	th occurred at the tin	ne, date and	place, and due	e to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil A. Meade 9811 Mallard Drive Laurel, MD 20708		To th within To th comp	Me	29b. Signature and title of certifier	/1//				
Neil A. Meade 9811 Mallard Drive Laurel, MD 20708				> 1/W/ 1/W///	1/ 19220		061	roner 2	0, 2007
	^	1		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)				
State 31. Date filled (Month, Day, Year) Registrar NOV 0 6 2007	2	100							
				NOV 0 6 2007 Signal D. Apper	K)				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Amend Item 8 per fin	e of Mar ,g873,1 1	yland / D L/21/07dh	epartment of Herificate of L	leaith and r D <i>eath</i>	vientai Hyg R	iene eg. No. 2 N N ~	7 37317
			Decedent's Name (First, Middle, Last)					2. Date of Deat	h	3. Time of Death
Н	Physici /Medic		Stanley Pa	1mer	Carg	o, Jr.		November	r 10, 2007	10:13 A M
	Examin		4a. Facility Name (If not institution, give street ar	d number)			Location of Death	1	4c. County of Dea	
			Garrett County Memori	al Hos	pital	0akland			Garrett	
۲.	Funeral		5. Social Security Number 6. Sex		(In yrs. last birt	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day;	11/10/1954 Bir	thplace (State or Foreign ountry)
	Director		103 46 3186	<u>'</u>	J4 \	rs. Days		Dec 10		PA
	and and		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town	or Location				10d. Inside City Limits
	vfaryl f sho led a	10	NC Gaston		C h	• -				1x Yes 2 No
	the 28a-	Director	NC Gaston 10e. Street and Number		Gaston	10f. Zip Code		1	0g. Citizen of What Co	ountry?
	3a ol	Ē	2436 East Chartres D	r		28056		1	USA	
	deatl ms 2	Funeral	11 Marital Status 12. Was	Decedent Eved Forces?	er in U.S.	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S		14. Race - Ame	
9	after or ite mlne	Fu	1 ☐ Never Married 2 🕅 Married 1 ☐	Yes 2 <u>√x</u> No s, Give)	1 ☐ Yes 2 ☑ No		o nican, etc.)	Black, White Specify: White Specify: White Specify: White Specify: White Specific Sp	
ဗ္ဗ	ours rral", Exa	d by	3 ☐ Widowed 4 ☐ Divorced Year	or Dates:						
5	72 h "natu	Completed	15. Decedent's Education (Specify only highest grade comple	eted)	16a.	Decedent's Usual Occup- (Give kind of work done of life. DO NOT use retired	during most of wor	king	16b. Kind of Business	/Industry
12	withir ene. than	du	Elementary/Secondary (0-12) Colle	ege (1-4or 5+) 4		ervice Advi	•		Toyota Dea	-1
d 2	filed Hygi ther		17. Father's Name (First, Middle, Last)		ne (First, Middle, M		arer			
an	d be ental ked o	To Be	Stanley P. Cargo Sr.				Annice	Adame		
3	should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship (Type. Prin	·)	19b.	Mailing Address (Street a			; City or Town, State, .	Zip Code)
Š	alth a 27 is 27 is r trai		Joy Cargo, Wife		24	36 E. Chart	res Dr.	Gastonia	a. NC 280	56
re,	os 1 a		20a. Method of Disposition		20b. Place of	Disposition (Name of y, crematory or other place			20c. Location - City or	
E	Page nent c unt: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State		Mem. Park	1	15/2007	Charlotte	, NC
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Funeral Service Licensee			22. Name and Addres			ırdock Fune	
<u></u>	8 3 E 8 8	1	Katherne Sweit	sur_		21 N. 2nd		Land, MD	21550	
h			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the on each line	he death. Do n	ot enter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition A	theros	cleroti	c Cardiovas	cular Dis	sease		Onset and Death Vears
	/Medical Examiner		resulting in death)	e to (or as a	consequence o	of):				
В	LAdillilei	L	Sequentially list conditions, b.		consequence o	¥.				
	ied isit	nine	cause. Enter Underlying Cause (Disease or injury	ie to tor as a	consequence o	ng.				
	ificate be executed g physician and as the burial-transit	Examiner	that initiated events c	e to (or as a	consequence o	of):				
68760,	e be e sician buria	al E								
289	ifficate g phy: as the	edical	0.							
Box		Physician/M		s, outcome pt		оП <u>я</u>			23d. Date of de	livery
	The law requires that the death cer Ite has been signed by the attendin age 2 should be detached for use	icia	in the past 12 months?	Pregnant at ti	Fetal death me of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
Vital Records, P.O.	w requires that the de been signed by the s should be detached i	hys	9 ☐ Unknown	Unknown						
S,	es th	by F	Part II. Other significant conditions contributing	to death but	not resulting in	the underlying cause give	en in Part I.		pacco use contribute to	
<u>S</u>	equir sen si ould	ted	Diabetes					1 □ Ye	es 2 No 3 P	robably 4 Dunknown
e C	law ras be	Completed						24a. Was a	sy prior to	utopsy findings available completion of cause of
<u> </u>		Con						perform 1⊟ Yes		s 2 No
Vita	rysician: Th nis certificate director, pag	Be	25. Was case referred to medical examiner?			Cub		th (Check only on	e)	
0	Phys this al dir	L 2	1 X Yes 2 No Hospital: 27. Manner of Death 28a.	1 ☐ Inpatient Date of Injury	2 ER/Out		4 Li Nursing H		ence 6 Other (Spe	ecify)
Division or	or Attending Physician: after death. Director: After this certific, in by the funeral director, i	ion	1 X Natural 5 ☐ Pending	(Month, Day	Year) 200. I	njury Worf	yat k? Yes 2∐No	Zou. Describe no	ow injury occurred	
<u>S</u>	death death ctor: y the	icat	3 Suicide 6 Could not be 28e.	28f. Location (St	reet and Number or R	ural Route Number.				
<u>S</u>	pital or Ai ours after o leral Direc filled in by	Certification:	4 Homicide determined	City or Tòwi	n, State)	,				
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Physician:							
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in by	Medical	(Check only 2 Medical Examiner: On one) and	the basis of e manner state		ovor investigation, in my o	pinion, death occu	urred at the time, d	late and place, and du	e to the cause(s)
	To the To the Complex	Ž	29b. Signature and title of certifier	1	4	29c. License	e number	2	9d. Date signed (Mon	th, Day, Year)
•			Dunguis 1.	0	45 1	D005	59898		11/10/200)7
			30. Name and address of person who completed							
			Douglas P. DeLo 251 31. Date filed (Month, Day, Year)			Street Oak	cland, MI	21550		
		State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature								
	3		140 A T 2 COD	1 Della						

ORIĞINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar		State	of Maryla	nd / Dep <i>Ce</i>	artmen rtificate	t of He	ealth a Death	ind Me		iene	200	7	373	18
			1. Decedent's Name (Firs	st, Middle, Las	")						2	2. Date of Dea Month		Ye		3. Time of D	eath
	Physici /Medio		Edith Fulle	er Clem	ent							Octobe:	r 31	, 20		9:45 p	ρм
	Examin		4a. Facility Name (If not in												eath		
			715 Maiden				5. last birthday			oville		Data of Biot		Balti			
	Funeral Director		5. Social Security Number 187–12–2403	4.0	X]M 2⊠XF	7. Age (iii yi		Months	Days	Hours	Min.	B. Date of Birth (Month, Day	, Year)			ace (State or F ry)	
	ס		Usual Residence of Dece									April 3	, 1	1923 Pennsylvania			
	nylan how			County		10c. 0	City, Town or Lo								10	d. Inside City	
	Ba-f	Director		Baltimo	re		Catons									1 ☐ Yes 2	3 XNO
	23a or 2	ai Dire	715 Maiden	Choice	Lane	Apt. CC	516	10f. Zip	212	228		1	0g. Citi	zen of What U	Count SA	ry?	
Maryland 21215-0036	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygene. Is marked other than "natural", or Iteme 23a or 28a-f ehow eumatic event, the Madical Examinational be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 3 ☑ Widowed 4 □ □		Armed F	2 X No ive	ĺ	Was Deced If Yes, spec			gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)		14. Race - A Black, V Specify:	/hite, e		
2-0	72 hc	eted	15. [(Specify on	Decedent's Edi	cation)	16a. Dece	dent's Usua kind of wor	I Occupa	tion	of working	,	16b. Ki	nd of Busine	ss/Ind	ustry	
2	Athin hen hen	Completed	Elementary/Secondary	, , ,	College	(1-4or 5+)	life.	DO NOT us	se retired)		or morning			Hor	m 0		
2	iled w tygier ther ti		17. Father's Name (First,	Middle (act)	4			ПОШ	emake		da Nama /	Circa Adiadallo	l da intara	Ho	ile		
and	0 =	Be	Fred Fuller									First, Middle, i Clarke		Sumame)			
2	should be and Mental marked o umatic eve	ဥ	19a. Informant's Name/F		voe. Print)		19b Maili	no Address	(Street a			Route Number		r Town Stat	e Zin i	Code	
<i>1</i> 0	od 2 :		Helen Cleme													, NY 10	0024
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any injury or other treumatic e <u>pnce</u> .		20a. Method of Disposition 1 Burial 2 Cre 4 Donation 5 Di	mation 3 🔲		State	Place of Dispo cemetery, cre etro Cr	osition (Nan	ne of ther place			er 5,	20c. Lo	cation - City	or Tov	vn, State	
Baltii	Departmit. P Departmit. Importar any injure.		21. Signature of Funeral Service Ucensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna 495 Gov. Ritchie Hwy. Severna													Home	
			23a. Pril 1. Enjer the dis	ease, or comp	cations that	caused the de	ath. Do not en	ter the mode	7. Kl	. TCN16	ardiac or i	 Severespiratory arr 	erna est.	Park		Approximate	
	Pnysician /Medical		hock, o heart failu In mediate cause (Final isease o condition resulting in death)	ire. List only o	á		munce of):	F	bru	SUS						Interval Betwe Onset and De	
	Examiner		Commented to the constitution			(.,.										
	cuted bd ransit	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	ns, ate	b. Due to	(or as a conse	equence of):										
8/60,	death certificate be executed e ettending physicien and id for use as the burial-transit	dicai Ex	resulting in death) Last	l	Due to	(or as a conse	equence of):										
٥	artifica ing ph e as ti	Med	IF FEMALE:				· · · · · · · · · · · · · · · · · · ·										
O. Box		Physician/Me	23b. Was decedent preg in the past 12 month 1 Yes 2 No 9 Unknown	Halli	1 Live	utcome of pregi birth 2 □ Fe inant at time of nown	tal death 3	□Ectopic pro □ Other (spe					2	23d. Date of Month		y Day Yea	ar
ב	requires that the de neen signed by the e hould be detached t	by	Part II. Other significant	conditions co	ntributing to	death but not re	sulting in the u	nderlying ca	ause give	n in Part I.				-		e cause of dea	
0	w requir been s	eted										1 L Y	es 24	⊅ No 3∟	Proba	ıbiy 4 ⊟Uni	known
	The la ete has page 2	Completed										24a. Was a autops perform	y	24b. Were prior death	to com	sy findings av ipletion of cau 2□ No	alable ise of
Z	Physician: Th this certificete rai director, pag	Be	25. Was case referred to examiner?	-	-lo coital:				011			Check only or					
0	shys this	1	1 Yes 2 No				ER/Outpatie		A Uther	4 Nur		5 Peside			Specity)	!	
	Hing After	tion		Pending investigation	(Moi	of Injury oth, Day Year)	28b. Time o Injury	M	8c. Injury Work	at ? es 2.⊡N		d. Describe h	ow injur	y occurred			
DIVISION	r Atten ter deal irector: I by the	Certification:		Could not be determined	28e. Plac build	e of Injury - At ling, etc. (Spec	home, farm, strify)					f. Location (Si City or Town	reet and n. State	d Number o	Rural	Route Numbe	∂r,
_	Hospite 4 hours Funeral	edicai C	29a. Certifier 12 (Check only one)	Certifying Phy Madical Exam	nar: On the I	e best of my kr pasis of examin	nowledge, deat nation and/or in	h occurred a	at the time in my opi	e, date and nion, deat	d place, and h occurred	d due to the c at the time, d	ause(s) ate and	and manne place, and	r as sta due to	ited. the cause(s)	
	ro the vithin 2 Fo the complet	Me	29b. Signature and title	certifier				29c	. License					e signed (M			
	. , , , ,) /	1	ND			D	474	147			No	venh	1	2017	
2	KAL		30 Name and address of	erson who c	ompleted cau		em 23a) (Type,	Print))	(an	9	Cate	750.	اد		,2017	
	Sta	te	31. Date filed (Month, Da	y, Year)	32.	Resistrar's Sign	nature										
	Registr	ar	NO	V 0 5 2	007	leen	H.	ball.									

DHMH 17 Rev 1/2001

ORIGINAL

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: To the Hospital of within 24 hours at To the Funeral D

1XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) 1 Maturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D57078

8:15 A M

1 ☐ Yes 2 X No

State Registrar

Director:

Be

Certification: To

Medical

31. Date filed (Month, Day, Year) NOV 0 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

Jacqueline S. Ryanzigo 32. Redistrar's Signature

			For State "					artment of H				iene			
Am	Physici	an	State Registrar# 2 1. Decedent's Name CHESTER		Last)	.,11/7	/07 Ce	rtilicate of i	Death	2.	Date of Dea Month 11/5/2	Day C	20 Qear7	3. Time of Death	
1	/Medi Examir				give street and nur	mber)		4b. City, Town, or	r Location of		11/5/2		ounty of Death		
			118 Eigh	nth Stre	et			Pocomoke	e City				Worces	ter	
	Funeral Director		5. Social Security 1 214–40–85	558	6. Sex 1 X M 2 ☐ F	7. Age (In yrs.	last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day /11/19	Year) 43	9. Birthp Coun Mary .		
	and		Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or Lo	ocation					1	0d. Inside City Limits	
	Maryl f sho	jo	MD Worcester Pocomoke					City						1 XYes 2 No	
	r 28a	Director	10e. Street and Nu	10f. Zip Code			1	l0g. Citize	n of What Cour	ntry?					
	th wit		118 Eight	h Stree	et			21851				τ	USA		
	ems er mu	Funeral	11. Marital Status			edent Ever in U	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Orig	in? (Specify	/ Yes or No-	14	. Race - Americ Black, White,		
36	rs afte	by Fu	1 ☐ Never Mar 3 ☐ Widowed	ried 2Marrie 4 □ Divorced	d 1 ☐ Yes 2X No			1 ☐ Yes 2 ☐ No		, ,	Specify: white				
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed I	(Spe	dent's Usual Occup		of working	T	16b. Kind	b. Kind of Business/Industry						
121	vithin nne. han "	ld m	Elementary/Sec	-4or 5+)	life.	DO NOT use retired	d)	o, womang							
	filled v Hygie ther t		17. Father's Name	(First, Middle, L	.ast)		Carpe	nter	18. Mother	r's Name (Fi		Construction Maiden Surname)			
Baltimore, Maryland	ld be ental ked o	To Be	Edward 3	John Cur	ran						Marti		,		
	shou ind M s mar umati	-	19a. Informant's N				19b. Maili	ng Address (Street	and Number	r or Rural R	oute Number	r, City or T	own, State, Zip	Code)	
	and 2 valth a n 27 is		Carol D.	. Curran	(wife)		118 E	ighth St.	, Poc	omoke	City,	MD 2	21851		
	of He		20a. Method of Dis		3 □ Bemoval from	I .	Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)	Date	'	20c. Loca	tion - City or To	own, State	
	Pag tment tant: I		1 Removal from State 4 Donation 5 Other (Specify) Bethany Methodist Cemetery 11/8/2007 Pocomoke City, MD												
Bail	permit Depar Impor any In once.		21. Signature of F	uneral Service L	icensee			2. Name and Addre							
			23a Part1 Enter	the disease or o	complications that c	aused the dea		03 Linder					, MD 21	851 Approximate	
	Dharitin		shock, or he	art failure. List c	inly one cause on e	ach line.	A.	L L	19, 30011 a3 C	cardiac or re	sopriatory arr	CSI,		Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death) a. Ord a first thing in death Due to (or as a consequence of):												
	Examiner				M.	10-25-0	tall	Afratio	M				-	3 weeks	
	E	ē	Sequentially list or in any, leading to in cause. Enter Und	mmediate	b. Due to	or as a consec	quence of).	- CICATO						<u> </u>	
	ecuted and transi	Examiner	Cause (Disease or that initiated event	r injury s	с										
30,	ficate be executed physician and sthe burial-transit	Ä	resulting in death) Last Due to (or as a consequence of):												
68760,	cate b	dical		'	d										
×6	certifi Iding Ise as	യ	IF FEMALE:		23c. If yes, out	come pf pregn	ancy				37111	220	d. Data of dollar	200	
m	death atter	ciar	in the past 12	2 months?	1 ☐Live b	irth 2□Feta ant at time of o	al death 3[□ Ectopic pregnancy □ Other (specify)					23d. Date of delivery Month Day Year		
o.	t the c by the achec	Physician/M	1 ☐ Yes 2 9 ☐ Unknowr		9□Unkno			- (, ,,							
S,	The law requires that the death certif tte has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute								contribute to the	to the cause of death?			
g	equire en siç ould b									_ [1 /X Y	es 2	No 3 ☐ Prob	ably 4 Unknown	
မင္ပ	law r as be	Completed									24a. Was a	in :	24b. Were auto	psy findings available mpletion of cause of	
三 四	The cate h	S S									perfori	med? 2. No	death? 1 ∐ Yes	2 X 1No	
Vite V	ician: Th certificate ector, pag	Be	25. Was case refe examiner?	_	Haspital:			Oth		of Death (C	heck only on	ne)			
0	Physical this cal direct	은	1 ☐ Yes 2 27. Manner of Dea		Hospital: 1 🔲 I	npatient 2	ER/Outpatier		4 ⊔ Nur	rsing Home	7		Other (Specify	y)	
0	ding h. After funer	ioi	1 Natural	5 ☐ Pending investiga	(Mon	th, Day Year)	Injury	Wor	yaı k? Yes —2 X ∫N		. Describe ho	ow injury c	occurred		
Division or Vital Records, P.O. Box	Atten deatl ector:	fical	2 ☐ Accident 3 ☐ Suicide	6 Could no	ot be 28e. Place	of injury - At h	iome, farm, st	reet, factory, office	724		Location (Si	treet and I	Number or Rura	l Route Number,	
	al or after	Certification:	4 ☐ Homicide		buildi	ng, etc. (Speci	ty)				City or Towi	n, State)			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier (Check only	1 Certifying	Physician: To the examiner: On the b	best of my kn	owledge, deat	h occurred at the tir	me, date and	d place, and	due to the c	ause(s) ar	nd manner as s	tated.	
	the H nin 24 the F nplete	Medical	one)		and man	ner stated.	adyn anu/of II			occurred i					
	7 with	2	29b. Signature and	title of certifier	00			29c. Licens					signed (Month,		
,			Do	hudl	peede	~ WD)	- Do	060	267	5	11/6	5/200	7	
6	SA3				h completed caus	e of death (Iter		-S+ P	ern m	roke	MD	218	51		

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Ma	aryland		tificate of		, ,	ene	07	27221	
	Physicia	an		Decedent's Name (First, Middle, Last)							Day 27	Year	3 Time of Deeth	
	/Medic	al	JOHN AUGUSTUS de GROOT 4a. Facility Name (If not institution, give street and number) 4b.						r Location of Death	OCTOBER		27 2007 1705PM 4c. County of Death		
	Examin	ier		4a. Facility Name (If not institution, give street and number) 7135 SOLITUDE ROAD					MI CHAEL:		TALBOT			
	Funeral	1 1 1 M 2 I F I					t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, DEC 24,	Year)	9. Birthp Coun PA	lace (State or Foreign itry)	
В	Director		204-03-2 Usual Residence	2020	X	85	TIS.			DEC 24,	1921	PA		
	ryland how		10a. State	10b. County		10c. City, 7	Town or Lo	cation				1	0d. Inside City Limits	
	ne Ma 8a-fs	Director	MD	TALBO	r	S	T. MI	CHAELS					1 □ Yes 2 No	
	death with the Maryland ms 23a or 28a-f show r must be notified at	Dir	10e. Street and N	olitude Re	OAD			10f. Zip Code 21	663	10	g. Citizen of \	What Coun	itry?	
	death	Funeral	11. Marital Status	3	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. V	Was Decedent of H f Yes, specify Cub	lispanic Origin? (S	pecify Yes or No-		e - Americ		
20	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	by Fu		arried 2 X Married	1 X Yes 2 □ N If Yes, Give	No		1 ☐ Yes 2 📉 No	Specify:	o i noan, etc.,	Specify	ck, White, white, which will be a second with the contract of		
-UU36	2 houn atural		3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education				16a. Deced	ient's Usual Occup	ation	- 1	l 6b. Kind of B			
<u> </u>	thin 72 ee. an "na Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)					kind of work done OO NOT use retired		king				
7	filed wi Hygien other th ent, the		12 4				OWNE	R/OPERAT		no (First Middle A	ARCHI'		RE	
anc	d be fi) Be		ie (First, Middle, Las ICK de GRO						ne <i>(First, Middle, N</i> GARET de		ne)		
ary	should and Men s marke umatic	2		Name/Relationship			19b. Mailin	ng Address (Street		ıral Route Number,		State, Zip	Code)	
2	1 and 2 Health a em 27 is		MARIE (de GROOT/I	WIFE					ST. MIC				
<u> </u>	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of D	•	Removal from State	- 1		sition (Name of natory or other plac	E .	Date	20c. Location -	- City or To	own, State	
Dallimo	iit. Pa artmen ortant: njury			n 5 ☐ Other (<i>Speci</i> Funeral Service Lice		ST.		H'S CEME R. Name and Addre	The second section of the second section of the second section of the second section s	/2/2007	CORDOV	A, MA	RYLAND	
מ	permi Depar impor any Ir	a a	Joseph	. 13		2.S.P.				N & NEWNA EASTON,	M FUNE	RAL H	OME PA	
ď			23a. Part1. Ente shock, or he	r the disease, or con	nplications that caused one cause on each lin	the death.							Approximate Interval Between	
	Physician	î	disease or condition disease or condition resulting in death) a. metastatic cancer of bladder 4 years										Onset and Death 4 46005	
	/Medical Examiner		resulting in death	<i>"</i>	Due to (or as	a consequer	nce of):						•	
B	L A	ner	Sequentially list of any, leading to cause. Enter Uni	conditions, immediate	b Due to (or as	a consequer	nce of):							
	ecutec and transi	Examin	Cause (Disease that initiated ever resulting in death	or injury nts	c						11/12			
00/00	icate be executed physician and s the burial-transi													
000	ificate g phys	edical			d									
Š	th cert	M/ne	IF FEMALE: 23b. Was decede		23c. If yes, outcome 1□Live birth			Ectopic pregnanc	v			te of delive	.,	
	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transitions.	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Ves 2 □ No 9 □ Unknown								Mo	Month Day Year		
ŗ	that the				contributing to death bu	ut not resulti	ng in the ur	nderlying cause giv	en in Part I.	23e. Did tob	ne cause of death?			
	quires an sign uld be	ed by								1 □ Ye	s 2 No	3 ☐ Prob	oably 4 □Unknown	
ט ט	law re as bee 2 sho	Completed								24a. Was ar		Were auto	psy findings available mpletion of cause of	
=	. The	Com								perform 1∐ Yes 2	ned?	death?	2 □ No	
V II c	sician certifi rector	Be	25. Was case ref		Hospital:			t 3000A Oth		th (Check only one				
5	g Physer this eral di	7: To	1 ☐ Yes 2	eath	28a. Date of Inju	ry 2	8b. Time of	1 3 DOX	4 Inursing F	ome 5 Reside 28d. Describe ho			y)	
2	ath. or: Aft	atio	1 ⊠Natural 2 ☐ Accident			y rear)	Injury		Yes 2 □ No					
2	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ury - At home c. <i>(Specify)</i>	e, farm, stre	eet, factory, office		28f. Location (Str City or Town	reet and Numb , State)	ber or Rura	al Route Number,	
7	spital ours a neral I		29a. Certifier	K Certifying P	hysician: To the best of	of my knowle	edge, death	n occurred at the ti	me, date and place	e, and due to the ca	ause(s) and m	anner as s	tated.	
	n 24 h he Fu	Medical	(Check only one)		miner: On the basis of and manner sta		n and/or in	vestigation, in my	opinion, death occi	arred at the time, da	ate and place,	and due to	o the cause(s)	
	Vithi Com	ž	29b. Signature at	nd title of certifier	1			29c. Licens		29	d. Date signe		*	
À		1	100	heball,	Juhe	MI			1867		10/2	29/0-	7	
+	-VA			£1	completed cause of de ER M.D. 511	,			STON MD	21601				
(K)	Sta			1"13°0 2007	32. Registra	ar's Signatur	TO ALLED	<u> 1363</u>	OLUM, EID	21001				
	Registr	ar			many.	~ 1	-							

DHMH 17 Rev 1/2001

		ŀ	For State Registrar	State of	Maryland		artment of				ene 200	17	37322			
	Physici	an	Decedent's Name (First, Middle,									e of Death nth Day Year				
	/Medic	al	Rita 4a. Facility Name (If not institution,		4b. City, Town	or Location of	Nof Death		4, 2007 7:21 P. M							
	Exami	ei	Brooke Grove Re				Sprin				Montgomery					
	Funeral Director		578-46-7156	6. Sex 1 □ M 2 🖾 F				r If Under	Min.	Date of Birth (Month, Day, arch 5,	Year) 1917	Birthplace (State or Foreign Country) NY				
	land ow		Usual Residence of Decedent 10a. State 10b. County									100	d. Inside City Limits			
	Mary n-f eh	tor	MD Montgomery Gaithersburg										1 ☐ Yes 2 🛣 No			
	or 28	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wh	at Countr	y?			
	eath v	Funeral	7909 Badenloch			13 1	208		ain? (Specif	Voc or No	United					
36	be filed within 72 hours after death with the Maryland Hygiene. Hygiene 4 heryland other than "natural", or iteme 23a or 28a-f ehow ovent, the Madical Examiner must be notilised at	by Fun	1 Never Married 2 Marrie 3X Widowed 4 Divorced	Armed For d 1 Yes If Yes, Give	1 ☐ Yes 2 K No			f Hispanic Original, Mexican of Specify:	n, Puerto Rio	an, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
Maryland 21215-0036	72 hou		15. Decedent's (Specify only highest	Education		16a. Deced	ient's Usual Occ	upation	t of working	1	6b. Kind of Busi					
2	ne.	Completed	Elementary/Secondary (0-12)	College (1-	-4or 5+)		kind of work dor DO NOT use reti		t or working							
2	filed v Hygie ther t									First. Middle, M.	Hom aiden Surname					
a	should be filed volud be filed volud Mental Hygie markad othar imatic event, it	To Be														
ary	2 should and Men ie marka aumatic		19a. Informant's Name/Relationshi			19b. Mailin	ng Address (Stre	et and Numbe								
	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other traumatic ev once.		Patrick Deely/So	n			Baden1o									
Baltimore,	Pages 1 nent of H nrt: if ite iry or of		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation :		State 200. Plac	netery, cren	sition (Name of natory or other p	1	Date		0c. Location - C					
	nit. Pa artmer ortent injury		4 Donation 5 Other (Specify) Gate of Heaven Cem. 11/08/2007 Silver Spring, MD. 21. Signature of Funeral Service Censes 22. Name and Address of Facility DeVol Funeral Home													
Ba	Departi Departi Importi eny Inje		Melica	1 lu	Lillin		East D						20877			
	Physician /Medical Examiner		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a. Due to (c	aused the death. PIRATION or as a conseque	once of):	NEWNO		cardiac or n	espiratory arres	st,	1 1	Approximate nterval Between Onset and Death			
8/60,	certificate be executed riding physicien end use as the burial-transit	Ical Examiner	Sequentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):													
ň	ath certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnar Other (specify)		23d. Date of delivery Month Day Year									
ecords, P	Se 00 0	þ										co use contribute to the cause of death? 2本No 3 □ Probably 4 □Unknown				
r	elaw hesb je2si	Completed	24a. Was an autopsy performed 1 ☐ Yes 2 ☑								ed? de:					
VITAI	sicien: Th certificete irector. pag	BeC	25. Was case referred to medical examiner?					26. Place	of Death	Check only one						
0	ing Phys Viter this uneral di	ion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date o	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. tnjury at Work?					ng Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred						
5	or Atten after deat Director; in by the	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place	M 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	Hospital or 24 hours efte Funeral Di etely filled in	edicai C	29a. Certifier 1 Cartifying (check only one)	Physician: To the xaminer: On the ba and mann	sis of examination	ledge, death on and/or inv	occurred at the vestigation, in my	time, date and opinion, deat	d place, and th occurred	d due to the cau at the time, dat	use(s) and mann te and place, an	ner as stat d due to ti	ted. he cause(s)			
	To the Hosp within 24 ho To the Fund completely f	Me	29b. Signature and title of certifier					nse number			d. Date signed (•			
			120kg	meim?			D33	700		N	Suche	er 5	7.005			
			30. Name and address of person w	ho completed cause	of death (Item 2	23a) (Type,	Print)					40				
	Sta	10	TED E. HOWE 31. Date filed (Month, Day, Year)	174 N.	HIZTIZA	h らば、	WILL	ANSPO	KT,	CW2	7179	>				
	Registr			2007	egistrar's Signatur	40	القامو									

			Please 1	Type or Prin								_			
			For State	State of Ma	ryland	•				ntal Hy	giene)			
			State Registrar	Cei	rtificate of	Death		. Date of Dea	Reg. No	200	3	7323			
	Physicia	an	Decedent's Name (First, Middle, Last,					Month	Da		3. 1111	E E S			
	/Medic		Ronald Warbur 4a. Facility Name (If not institution, give		Sr.		4b. City, Town,	or Location		ovembe		, 2007 . County of Dea		55 PM [™]	
	Examin	er	43 Basil Avenue	street and number)			Chesa					Cecil	.,		
	Funeral	esi	5. Social Security Number 6. Se	x 7. Age	(In yrs. la	st birthday)	If Under 1 Yea	If Unde	r 24 Hrs. 8.	. Date of Birt	th	9. Bir	hplace (St	ate or Foreign	
	Director		215-34-0051	XM 2□F	59	Yrs.	Months Days	Hours	Min.	(Month, Da			uintry) rv1an	d	
Arth	D		Usual Residence of Decedent						1 1						
	show	l _m	10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits 1 X Yes 2 No		
	Ba-f s	Directo	Maryland Cecil		Che	sapeal	ke City				1- 0"	. Citizen of What Country?			
	vith the	Ö	10e. Street and Number				10f. Zip Code	_			Ü	•			
	s 23e	Funeral	43 Basil Avenue	12. Was Decedent E	war in II S	12.1	2191		rigin? (Specif	hi Voc or No		ited St		n.	
	Item Item	Ľ.	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces?	ces? If Yes, specify Cuban, Mexican, Puèr					can, etc.)		Black, Whit			
5	irs af	by F	3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates: N	n Na	t.	1□Yes 2XN	Specify	/ :			Specify: W	nite		
2-003p	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	ted	15. Decedent's Edu	16a. Dece	dent's Usual Occi		at of working		16b. K	ind of Business	Industry				
7	hin 7 e. an "n Medi	Completed	(Specify only highest grad Elementary/Secondary (0-12)	ed)	ist of working										
V	gen with	NO.	12	visor of					ducatio	on					
and	be filed within 7 ntal Hygiene.	Be (17. Father's Name (First, Middle, Last)							me (First, Middle, Maiden Surname)					
<u>Xa</u>	2 should be and Mental is marked raumatic ev	ဥ	John S. Dean					1		beth Kibler					
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (7) Barbara Dean / Spe	pe. Print) Ouse			g Address <i>(Street and Number or Rura</i> Isil Avenue, Chesa				21915				
e 'o	1 and Health Sm 27 ther to		20a. Method of Disposition		20h Pla	ace of Disno	sition (Name of	ī				ocation - City or			
0	Pages nent of I nt: If Ite		1X Burial 2 □ Cremation 3 □ F		ce	metery, crei	matory or other p	4	Novem						
altimor	it. Pa .rtmei .rtant njury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Septice Ligens	2	Nor		st Metho		7, 20			th East	, Mar	yland	
מ	Depariment of the permit of th		21. Signature of Funeral Septice Licenses 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryla:										nd21901		
	TO SE	_	23a. Part1. Enter the disease, or comp	lications that caused	the death.								Approx	imate	
ø	Physician		shock, or heart failure. List only o Immediate Cause (Final	-			(lan			.01			Onset	l Between and Death	
×.	/Medical		Immediate Cause (Final disease or condition resulting in death) a. CONGESTINE NEART FATLURE Due to (or as a consequence of):										1/10.1	2471	
ı.	Examiner			cono	NAR	LY	ARTER	V	ATS	EASE	_		YEA	RS	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
1	executed n and ial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):											
Š,	be exe	Ě	resulting in death) Last	Due to (or as a	a conseque	ence of):									
	eath certificate be executed attending physician and for use as the bunal-transit	dica	d.												
٥ ×	death certificate e attending physi d for use as the	Physician/Medica	IF FEMALE:	23c. If yes, outcome	ncv						00d Date of de	livane			
X P Q	atten for us	ian	in_the past 12 months?	1 ☐ Live birth	□ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy □ Pregnant at time of death 5 □ Other (specify)						23d. Date of de Month				
j	the di y the ched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown											
7	w requires that the death been signed by the atte should be detached for									23e. Did tobacco use contribute to				e of death?	
cords	quires n sign ald be	d by	COPD							120	1 Yes 2 No 3 Probably 4 Unknown				
ပ္ပ	law re as bee 2 sho	Completed	Type I Nich	eter Mel	litu		24a. Was a								
ř	sician: The law certificate has t irector, page 2 s	mo	ATREAL FLU	_						auto perfo 1 Yes	psy ormed? 2 X N	death?			
	ian: rtiffica tor, p	BeC	25. Was case referred to medical					26. Plac	ce of Death (ath (Check only one)					
	Physician: r this certific ral director,	To E	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 🗆 E	R/Outpatier	nt 3□ DOA	ther: 4 🗆 N	Nursing Home	e 5 ⊠ Resi	idence	6 □Other (Sp	ecify)		
	ding Pt h. After th funeral	:uc	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year)	28b. Time o	W	ury at ork?	28	28d. Describe how injury occurred					
VISION	Attending or death. ector: After by the funer	catio	2 Accident investigation 3 Suicide 6 Could not be					Yes 2							
<u> </u>	or At fter d Direct in by	Certification:	4 Homicide determined	28e. Place of inju building, etc			reet, factory, offic	e	28	City or To		nd Number or F le)	urai Houte	Number,	
_	ipital or ours afte eral Dii filled in		29a, Certifier 1 XCertifyIng Phy	rsician: To the best of	of my know	vledne deat	h occurred at the	time date :	and place, an	nd due to the	cause(s) and manner a	s stated		
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the t	edical		iner: On the basis of and manner sta	examinati									use(s)	
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title/pf certifier				29c. Lice	nse number	r		29d. Da	ate signed (Mor	th, Day, Ye	ear)	
)			1 /2 and	toda			CIE	0006	397		i	1/6/0	7		
			30. Name and address of person who a	ompleted cause of de	eath (Item	23a) (Type,	Print)	/						10-	
10	24/VA			enTTTIO	45%	2 Ki	Kwad 1	tighus	y Suit	e 301	WI	mington	Del.	19805	
c.	Sta Regista		31. Date filed (Month, Day, Year) NOV .7 2(32. Jegistra	ar's Signat	K A	Print) Kwad /	, /		ĺ		•			

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d, Date signed (Month, Dav. Year)

Physician /Medical **Examiner** The law requires that the death certificate be executed the attending physician and Division or Vital Records, P.O. Box 68760, signed by the

this After t 24 hours after death e Funeral Director: filled in by

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show edical Examiner must be notified at

e filed within 72 hours after de Il Hygiene.

other than "natural", or Item

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Egone.

Director

Funeral

ģ

Completed

Be

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death with the Maryland

Physician/Medical ģ Completed Be (Certification: To Medical

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Examiner

within 24 BA 4+1

DHMH 17 Rev 1/2001

Hospitai or Attending Physician:

State Registrar

31. Date filed (Month, Day, Year) NOV 07 2007

30. Natine and address of person who completed cause of death (Item 23a) (Type, Print)

investigation

6 Could not be determined

STEVEN HAMLETTE, M.D 100 E. 32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

		For State Registrar	State o	of Marylan		artmen rtificate			nd Me	-	giene Reg. No.	200	7	3732	25
		Decedent's Name (First, Middle, L.)	ast)						2.	. Date of De	eath			3. Time of Death	1
Physicia /Medic		Ado1ph	A. F	riedman					N	Month OV	4 ,	200°	ear 7	1500	M
Examin		4a. Facility Name (If not institution, gi	ve street and nu	mber)		4b. City,	Town, or I	_ocation of	Death		4c.	County of I	Death		
The book confine comment		5450 Whitley P	ark Ter				hesda		-			Mont			
Funeral		,	Sex 1.∏XM 2.□F	7. Age (In yrs.	* .	If Under Months	1 Year Days	If Under 24 Hours		Date of Bir (Month, Da	th ay, Year)		Count	ace (State or Fore ry)	-
Director		579-46-6788 Usual Residence of Decedent			90 ^{Yrs.}					Oct.	4, 19	1/ 1	enn	sylvania	
land ow It		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10	d. Inside City Lim	its
Mary -f she fied a	ţō	Maryland Montgo	mery	Ве	thesda									1 X Yes 2 □ I	No
r 28a	irec	10e. Street and Number				10f. Zip					10g. Citiz	en of Wha	at Count	ry?	
th witl 23a o 1st be	a D	5450 Whitley Par	k Terra	ce, # 9	04	2	0814					U. S	. A.		
DEALLITIOFE, INIGITY IGHTIQ ZIZIO-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fulury or other traumatic event, the Medical Examiner must be notified at once.	/ Funeral Director	11. Marital Status 1 □ Never Married 2 【X Married	Armed F 1 XYes If Yes, G	2□No Ar	my	Was Deced If Yes, spec 1 ☐ Yes	cify Cubar	panic Origi n, Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No can, etc.)		I4. Race - Black, Specify:	White, e	etc.	
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Hilled Hygi		17. Father's Name (First, Middle, Las			1			18. Mother	's Name (F	irst, Middle	, Maiden	Surname)			
/Idno	To Be	Benjamin Fried	lman					He	elen	Margo	lis				
Mary d 2 shouth and h	_	19a. Informant's Name/Relationship Florence H. Frie		Wife	19b. Mailin 5450	ng Address Whit	(Street a	^{nd Number} Park	r or Rural F Terra	Route Numb	per, City or 904	Town, Sta	_{ate, Zip} heso	Code) la, Md 20814	
Heal Heal tem 2		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nar	ne of	ŧ	Dat			cation - Cit			
ages ent of it: If it		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		i State	cemetery, cirer Idean M	•			1/6/2	2007	01n	ey, M	ary.	Land	
Dallimor Definit. Pages Department of Important: If it Iny Injury or o		21. Signature of Funeral Service Lice		100			_	of Facility	nera1	Dire	ctio	n. In	c.		
Departiment once	100	Tonald C.	Xto	ttlemes	ch_ 1	091 F	Rockv	ille i	Pike,	Rock	vill	e, Ma	ry1a	and 208!	52
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/Medical Examiner		resulting in death)		(or as a consec											
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ted sit	Examiner	Sequentially list conditions, at cause. Enter Underlying Cause (Disease or injury that initiated events		OPD	querice or).										
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Or VII(al Records, P.O. BOX or Physician: The law requires that the death certificate has been signed by the attending trial director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregn birth 2 DFeta		∃Ectopic p	regnancy				2	23d. Date o	_	,	
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dlng h. Afte fune	ţ	1 XNatural 5 ☐ Pending 2 ☐ Accident investigati	(Mo	nth, Day Year)	Injury	м		? ∕es 2⊟N			•	•			
INISION I or Attending after death. Director: After	fica	3 Suicide 6 Could not 4 Homicide determine	_ 1 28e. Plac	e of injury - At h	ome, farm, str	reet, factor	y, office		28				or Rura	I Route Number,	
al or all or al Direction to the second to t	Certification:	4 Homicide	- Bull	ding, etc. <i>(Speci</i>	119)					City or 10	own, State	,			
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying I	Physician: To the	ne best of my kno	owledge, deat	th occurred	at the tim	e, date and	d place, an	d due to the	e cause(s)	and mann	ner as st	ated. the cause(s)	
the H iin 24 the F	ledical	one)		nner stated.						1					
To To	Σ	29b. Signature and title of certified	/ //	1.14		29	c. License D 2	number 0388						Day, Year) , 2007	
12		Howard	1800	well		W									
		30. If me and address of person with Howard S. Gold	o completed cau dstein.	use of death (Iter $ extbf{M} ullet extbf{D} ullet extbf{1}$	m 23a) (Type, L 0 4 0 1 O	old Ge	eorge	town	Road,	Suit	e 10	4, Be	the	sda, Md.	
Sta	ate.	31. Date filed (Month, Day, Year)		Registrar's Sign	ature								20	0814	
_ 011		NUV 05 2	HII K	A	K No	acht B									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 31, 2007 **Physician** 5:07A. Betty Foster /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Holy Cross Hospital Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Dec. 19, 1919 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F 87 Germany 364-20-5766 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Burtonsville Maryland Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20866 United States 3105 Winifred Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify. 3 X Widowed 4 □ Divorced Year or Dates Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) Homemaker own home permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If item 27 is marked other any Injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (unk) (unk) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3105 Winifred Drive Burtonsville, Maryland 20866 Joseph A. Foster -son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan Crematory 11/2/2007 Alexandria, Virginia 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mĭll Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Septic Shock /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760 physician Physician/Medical the as attending IF FEMALE nse s 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🛛 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Acute Renal Failure; Respiratory Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2X No has page this certificate 1☐ Yes Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes 2 🛱 No မ To the Hospital or Attending Physical 2 within 24 hours fer death.

To the Funeral Director After this completely filled in by the funeral director and the funeral director the funeral director and the funeral director and the funeral director and the funeral director and the funeral directors. 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year) NOV 06 2007

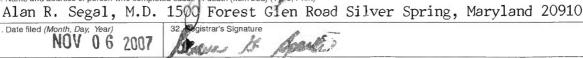
29b. Signature and title of certifier



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e

30. Name and address of person who completed causa (f death (item 23a) (Tyre, Print)



29c. License number

D52261

29d. Date signed (Month, Day, Year)

November 1, 2007

			For	State of N	laryland /	/ Departm	ent of H	ealth a	nd Mental H	ygiene)		
			1 State Registrar			Certific	cate of l	Death		Reg. No	200	7 0700	_
			1. Decedent's Name (First, Midd	lle, Last)					2. Date of I		201	3. Time of Death	_
	Physic /Medi			OLGA I.	FISH	ER			Month NOV •	4 ,	2007	11:09 A ^M	ı
e .	Exami		4a. Facility Name (If not institution	on, give street and numbe	r)	4b. (City, Town, or	Location of	Death		County of Dea		_
			GREATER LAUR	EL HEALTH A	ND REHAI	B.CTR.	LAU	REL			PRINCE	GEORGES	
	Funeral		5. Social Security Number		Age (In yrs. last	birthday) If U Mon	nder 1 Year ths Days				9. Bi	rthplace (State or Foreign	7
ed.	Director		088-12-9916	1 □ M 2 X □ F	86	Yrs.	uio Days	110013	SEPT.	8, 19	921 N	EW YORK	
	pui »]	Usual Residence of Decedent 10a. State 10b. County		100 City To	own or Location							_
	shorts shorts at at	5			Too. Oity, 11	OWIT OF LOCATION						10d. Inside City Limits	
	he M 8a-f otifie	Director		ARUNDEL			MBRILL	S		,		1 X Yes 2 □ No	
	with t		10e. Street and Number			10f	. Zip Code			10g. Citi	zen of What C	ountry?	
	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	Funeral	970 FALL R					1054			U.S.A.		
	er de item	Ë	11. Marital Status 1 □ Never Married 2 □ Mar	12. Was Deceder Armed Forces	s?	13. Was D If Yes,	ecedent of Hi specify Cuba	spaпic Origii п, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	lo-	Race - Am Black, Wh		
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	be filed within 72 ho ital Hygiene. d other than "natur event, the Medical	Be C	17. Father's Name (First, Middle,	, Last)					s Name (First, Middle			V 1.	_
Maryland		To B	NICHOL	AS IVKO					MARY	τ	YROK		
ary	de E	-	19a. Informant's Name/Relations		1	9b. Mailing Add	ress (Street a	and Number	or Rural Route Num			Zip Code)	_
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			23a. Part1. Enter the disease, o	r complications that cause	ed the death. D	o not enter the	mode of dying	, such as ca	ardiac or respiratory	arrest.	ili, III.	Approximate Interval Between	
	Physician		shock, or heart failure. List Immediate Cause (Final									Interval Between Onset and Death	
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	£ 5			_									
Вох	death certifica e attending pl d for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e pf pregnancy 2 ☐ Fetal dea	oth 3□Eston				2	23d. Date of de	livery	
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č	The lay	Eo							pen	opsy ormed?	prior to death?	completion of cause of	
ita	ian; rtifica ttor, p	Be C	25. Was case referred to medica					26. Place of	1	2 X No	1 Li Yes	3 2 □ No	
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Division or Vital Records,	ig Ph ter th neral	Ę	27. Manner of Death	28a. Date of In		Time of	28c. Injury Work	at	28d. Describe			iony)	_
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<u> </u>	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could determ	lined 28e. Place of Ir	ijury - At home, etc. (Specify)	farm, street, fac	ctory, office		28f. Location	Street and	Number or R	ural Route Number,	the state of
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	lospi hour uner uner		29a. Certifier 1 Certifyir (Check only 2 Medical	ng Physician: To the bes	t of my knowled	ge, death occur	red at the tim	e, date and p	place, and due to the	cause(s)	and manner a	s stated.	_
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	01707	Examiner: On the basis and manner s	tated.	and/or investiga	uon, in my op	miori, death	occurred at the time	, date and	piace, and du	e to the cause(s)	
	Verith Con	Σ	29b. Signature and title of certifie	(D)			29c. License	number		29d. Date	e signed (Mon	th, Day, Year)	
)	3			The state of the s	er A	N-12	D24	721		N	OV. 5,	2007	
	2		30. Name and address of person	who completed cause of	death (Item 23a) (Type, Print)							_
				DIQ, M.D.		3 LAURE	L BOWI	E RD.,	SUITE 208	B, LA	UREL, M	ID. 20708	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 6	2007 37 Regist	trar's Signature	break	D						
	166 81	5 U		C. LALLE M. T. M. T. Marrier and P. M. C. Marrier and P. M. Marrier and P. M. Marrier and P. M. Marrier and P. M. Marrier and P. M. Marrier and P. M. Marrier and P. M. Marrier and P. M. Marrier and P. M. Marrier and P. M. Marrier and P. M. Marrier and P. M. Marrier and P. M. Marrier and P. M. Marrier and P. M. Marrier and P. M. Marrier and P. M. Marrier and P. M.	- //3	AL AND MARKET SET SET	er.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Maizie Marie Fitzgerald 2007 Nov. 3, 3:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Harbor Nursing Home Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Sept 23, 1 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 28 F 90 212-24-4902 1917 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Prince George's Y☐Yes 2☐No Maryland Riverdale Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6428 Auburn Avenue 20737 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2**K** No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No White Specify δ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: if item 27 is marked other 1 any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Alexander Hooper Anna Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy J. Fitzgerald - Husband 6428 Auburn Ave., Riverdale, MD20737 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Dogation 5 Other (Specify) Fort Lincoln Cemetery 11/7/07 Brentwood, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. MON91 ase, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Let only one cause on each line. Hyattsville, MD Part1. Enter the disease shock, or heart failure. .! Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a cons quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) Ö Tyes 2 No. the 9 ☐ U*n*known signed by t d be detach 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy certificate 2 D N or Attending Physician: 25. Was case referred to edical examiner? 26. Place of De Check onl one Be Hospital: Other: 4 Narsing Home 1 ☐ Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After thi funeral 28a. Date of Injury (Month, Day Year) Death 27. Manner 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 tural within 24 hours arter control to the Funeral Director: Aft 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 6 ☐ Could not be. 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determine 4 Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

Njideka Udochi, 31. Date filed (Month, Day, Year) NOV 0 6 2007

30. Name and address/of person who completed cause of death

MD

29b. Signature and title of certifier

32. Registrar's Signat

and manner stated

29d. Date signed (Month, Day, Year)

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Jeffrey Allen Feldman 11:30 P M Oct 31 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 610 Cypresspointe Drive Severna Park Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1XM 2□F Months Days Hours 217-50-6419 60 Aug 23,1947 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel 1 □Yes 2 No Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 Cypresspointe Drive 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married 1 X Yes 2 □ No 1970 – If Yes, Give Year or Dates: 1974 1 ☐ Yes 2 X No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Mental Health Elementary/Secondary (0-12) College (1-4or 5+) Counselor Substance Abuse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martin Feldman Irene Katz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RoseAnn Feldman/ Wife 610 Cypresspointe Drive, Severna Park, MD 21146 ^{Date} 6,2007 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State Bestgate Memorial Annapolis, MD 4 □ Denation 5 ☐ Other (Specif) 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Ignature Funeral Service 495 Gov. Ritchie Hwy, Severna Park, MD 21146 rt1. Inter the disease, or conock, or heart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Imprediate ause (Final rease of condition sulting in death) Metastatic bladder cancer Due to (or as a consequence of): S quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No autopsy performed? 2 No 25. Was case referred to medical examiner?

Physician /Medical Examiner

physician

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ral", or items 23a or 28a-f shov Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural," or items 23a or any Injury or other traumatic event, the Medical Examiner must be none.

Baltimore, Maryland 21215-0036

Directo

Funeral

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Completed

Be

2

Physician/Medical Examine as the burial-trai nse for ed by the a detached for s been signed b þ Completed After this certificate has funeral director, page 2 Be 2

Certification:

Medical

requires that the death certificate be executed

P.O. Box 68760.

Division or Vital Records,

23b. Was decedent pregnant

1 Yes ≥ No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

29b. Signature and title of certifier

		_լ ս⊔	Yes	_2)<	Ų
26.	Place of Death	(Check	only	one)	
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=0.1 1000 01 000	ter (errock only one)
her: 4 Nursing H	lome 5 Residence 6 □Other (Specify)
uryat ork?]Yes 2 ☐ No	28d. Describe how injury occurred
	28f. Location (Street and Number or Rural Route Number, City or Town, State)

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only one)

28a. Date of Injury (Month, Day Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

homes M. Walsh MD

29c. License number

01

1[

28c. Inju

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

277 Peninsula Farm ROAD ARNOLD MD 21012 1HOMAS WALSH, M.D 31. Date filed (Month, Day, Year)

Registrar

NOV 0 5 2007

5 Pending investigation

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Day Daisy Virginia Cibson 2007 10 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death TALBOY MEMORIAL HOSPITAL EASTON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 M 2 J 02/11/1928 213-22-7138 MD Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Talbot Easton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 506 Doverbrook Apts 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2∏ No Specify: Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Someone elses home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Benjamin Gibson Sophie Blackwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6809 Bobtown Rd. Hurlock, MD 21643 William Frazier / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Richards Memorial 10/17/07 Easton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home ummie 426 E. Dover St. Easton, MD 21601 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Chnonic Obstructive Due to (or as a consequence of): monar Equentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes → No 24a. Was an 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 🕦 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death

Physician /Medical Examiner

be executed

Division or Vital Records, P.O. Box 68760,

GIBSON

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

filed within 72 hours after

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Mediconce,

3altimore, Maryland 21215-0036

burial-transit and ed by the attending physician detached for use as the burial Physician/Medical þ Completed certificate has Be this

funeral director, After t Certification: death. after death. filled in by the

To the Hospital or within 24 hours at To the Funeral D State Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 riflying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29b. Signature and title of certifier

1)0053110

1 ☐ Yes 2 ☐ No

Easton, MD 2160

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shelds 219 South Washington ST De

5 Pending investigation

6 Could not be determined

31. Date filed (Month, Day, Year) OCT 2 2 Registrar's Signature 2007 22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No.2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 03, ZOOT **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hebrew Home of Greater Washington Montgomery Rockville 8. Date of Birth (Month, Day, Year) 12/13/1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 F 218-92-1620 92 Ukraine Director Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1□Yes 2□No traumatic event, the Medical Examiner must be notified Funeral Director Rockville Md. Montgomery 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural any highy or other traumatic management of the properties." 6121 Montrose Rd. 20852 US 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 ☑ No ve White 1 ☐ Yes 2 ☒ No Specify: Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shahet Maria Munya Grushko ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11815 Pittson Rd. Silver Spring, Md. 20906 Yakov Epelboim/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery 11/5/2007 Adelphi, Md. 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Funeral Service Licensee Rockville Pike Rockville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Vear Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of has death? certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 ☐ Yes 2 ER/Outpatient 3 DOA After this 27. Manual of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

ONTROSERD, ROCK VILLEMD20J52 egistrar's Signature

29d. Date signed (Month, Day, Year)

35436 NOVEMBER 03, 2007

29b. Signature

and manner stated

			For State Registrar	State of Ma	ryland / Depa <i>Cel</i>	artment of H			giene 007	37332
	Physici		1. Decedent's Name (First, Middle, Last) Keyliejah Love G	rant				2. Date of Dea Month October		3. Time of Death 7:20P. M
	/Medio Examin		4a. Facility Name (If not institution, give s Holy Cross Hospita	1		Silver S			4c. County of Death Montgome	ry
	Funeral Director		5. Social Security Number 6. Sex 1000 C 1000	7. Age	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birtl (Month, Day OC LODE)	y Year 1,07 Mar	nplace (State or Foreign untry) cyland
	the Maryland 28a-f show	ector	10a. State 10b. County Maryland Montgomer 10e. Street and Number	у	10c. City, Town or Lo				10g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 No untry?
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other than "netural", or Itema 23e or 28e-f show any injury or other traumatic event, Ire Madical Extraliger outsite mailled at once.	Funera	3118 Whispering Pir	les Drive, 12. Was Decedent E Armed Forces? 1 □ Yes 2 ▼ N If Yes, Give Year or Dates:	ver in U.S. 13.	20906 Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	United St 14. Race - Ame Black, White Specify:	rican Indian,
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Maryland	should be filed ind Mental Hygi marked other umatic event, II	To Be (17. Father's Name (First, Middle, Last) Paul Jerome Holt				Neketa O	. Grant		
Baltimore, Mar	Pages 1 and 2 sho nent of Health and int: If item 27 Is m iry or other traum		19a. Informant's Name/Relationship (Ty, Neketa O. Grant - m 20a. Method of Disposition 1	other	B118 V	Misperin psition (Name of matory or other place	g Pines D	rive,#1	4 Silver Si 20c. Location - City or	ring,Md.
Baltin	permit. P Departme Importan any injury		21. Signature of Funeral Service License	gwall	Då	2. Name and Addre	Borgwardt	Funera	1 Home, PA	vland 20705
8760,	Cate be executed // // // // // // // // // // // // //	dical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Respira Due to (or as a Probabl Due to (or as a Extreme	tory Failua consequence of): e Sepsis a consequence of): Prematur: a consequence of):					Approximate Interval Between Onset and Death
Box 6	ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of the first term of the fir	2 ☐ Fetal death 3 [Ectopic pregnancy Other (specify)	,		23d. Date of del Month	ivery Day Year
Records, P.O.	w requires that the de s been signed by the a should be detached to	ρ	Part II. Other significant conditions cor	tributing to death bu	ut not resulting in the u	inderlying cause giv	en in Part I.	23e. Did to		robably 4 Unknown
al Reco	iicien: The law r certificate has bu rector, page 2 sh	Completed						1 X Yes	prior to death? 2 □ No 1 □ Yes	utopsy findings available completion of cause of
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Division of	ling Atter	Certification: T	27. Manner of Death 1	28a. Date of Injur (Month, Day	y 28b. Time o Year) Injury	M 1□	k? Yes 2 □ No		now injury occurred Street and Number or Re	ural Route Number
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	To the Hospital within 24 hours and the Funerel completely filled	ledical	(Check only 2 Medicef Exemi	ner: On the basis of and manner sta	examination and/or in	ivestigation, in my o	pinion, death occur	ed at the time,	date and place, and due	o to the cause(s)
)	To the within To the comp	Me	29b. Signature and title of certifier	is Oak	_ MD	29c. Licens D006			29d. Date signed (Mont November 3	
_			30. Name and address of person who or Jessica D. McAdoo,	M.D. 150	O Forest (Silver S	pring,	Maryland 20	910
	Sta Regist		31. Date filed (Month, Day, Year) NOV 0 6 200	32 Registra	ar's Signature	CALES				

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		_	Garrett County 5. Social Security Number	Memorial 6. Sex	1	ITAL (In yrs. last birthda		land	If Under	24 Hrs	O Data of Rise		rrett	-lass (Ctata 1	C
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	be filed within 72 hours after death with the Maryland stal Hygiene. diother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was De		er in U.S. 13	. Was Dece	dent of Hi	spanic Ori	igin? (Sp	pecify Yes or No		Race - Ameri		
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Maryland	and and is m		19a. Informant's Name/Relation			19b. Mai	ling Address	(Street a	and Numbe	er or Rui	al Route Numbe	r, City or 1	Town, State, Zi	Code)	
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	and and il-tran	Examiner	that initiated events resulting in death) Last	c	(or as a c	consequence of):									
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Вох	leath certific attending p I for use as	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	tcome of		□⊏atania ar					230	d. Date of deliv	ery	
	ed for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at tin		□Ectopic pr □ Other (sp						Month	Day Yea	ar
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<u>=</u>	Physician: r this certifice ral director, p	To Be	examiner?	Hospital:	Inpatient	2 ER/Outpatie	ent 3 DC	Othe			th <i>Check</i> only on ome 5 ☐ Resid		Other (Speci	6.1	
0	g Phy er thi		27. Manner of Death	28a. Date		28b. Time		8c. Injury Work			28d. Describe h			97	
į	Attending in death. octor: After by the fune	atlo		igation	iii, Day i	(e <i>ar</i>) Injury	м		es 2□	No					
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Plac	e of Injury ling, etc. (- At home, farm, s (Specify)	treet, factory	, office			28f. Location (S City or Tow		Number or Run	al Route Numbe	r.
۵	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral														
	Hospital 24 hours a Funeral i	edicai	29a. Certifier 1 ☐ Certifyii (Check only 2 ☐ Medical	ng Physician: To the Examiner: On the	e best of a pasis of ea ner state	kamination and/or i	ith occurred nvestigation	at the tim , in my op	e, date an sinion, dea	d place, th occur	and due to the or red at the time, or	cause(s) ar date and pl	nd manner as s ace, and due t	tated. o the cause(s)	
	To the vithin 2 To the comple	₹ e	29b. Signature and title of certific		IIIOI State	-	290	. License	number			29d. Date s	signed (Month,	Day, Year)	
	-> - 0)	1 Jena	1n			1)	15	33	3	11	19/0		
			30. Name and address of person	who completed cau	se of dea	th (Item 23a) (Type	, Print)			00		- 4	, , ,		
		10	Dr. Thomas John	nson, M.D	., 31	1 N. Fou	rth St	., C	aklaı	nd,	MD 215	50			
	Sta	te	31. Date filed (Month, Day, Year,	32.	Registrar's	Signature		and the							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 2, 2007 Рм **Physician** Albert Edward Gray /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ★M 2 ☐ F 73 1934 Maryland July 17, 579-48-2233 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heatth and Mental Hygiene.

Em 27 is marked other than "natural", or items 23a or 28a-f show ither traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 ☐ No Directo Maryland | Anne Arundel Edgewater 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21037 USA 109 Riverside Drive Completed by Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Almed Porces:
1 ☐Yes 2 ☐ No
If Yes, Give
Year or Dates: 1951-55 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Meat Cutter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Bell Finnacom Albert Gilbert Gray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1269 Crossover Drive Edgewater, Maryland 21037 Pages 1. vent of Hea. t: If item 2: Robert K. Johnson / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important; If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-8-2007 Davidsonville, MD Lakemont Cemetery 5 Other (Specify) 4 ☐ Donation 21. Signature of n ral Softice 22. Name and Address of Facility George P. Kalas Funeral Home 23r. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Imme the Cause (Final disease or condition resulting in death)

a. Due to (arrespiratory arrest) 2973 Solomons Island Rd. Edgewater, MD 21037 **Physician** /Medical Examiner iver ticulit Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner requires that the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Vear in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 3 Probably 4 nknown 1 ☐ Yes relency 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy performer es 21 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA ^oL this 27. Manner of Peat 1 Natural 2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral Certification: (Month, Day Year) Injury or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registra's Signature

DHMH 17 Rev 1/2001

29c. License number

D24804

Annopoles Md 21204

			1 - For State Registrar	State of N	Marylar		artment of H tificate of	lealth and l <i>Death</i>		giene Reg. No. 2007	37335
	Physici /Medi		Decedent's Name (First, Middle, L Helen	,	auline	<u> </u>	Han	sroth	2. Date of De	er ^D Ø, 2007	3. Time of Death 4:35 а м
	Examir		4a. Facility Name (If not institution, gr Williamsport Nu				4b. City, Town, o Willia	r Location of Death		4c. County of De Washin	gton
	Funeral Director		232-32-7305	Sex 7. / 1 M 2√√F	Age (In yrs. 96	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Dec 2	9. E 18, 1910 We	irthplace (State or Foreign Country) St Virginia
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County WV Morga	n		y, Town or Lo	cation Springs				10d. Inside City Limits
	with the 3a or 28a	i Direc	10e. Street and Number 509 N. Washing	ton Street	t		10f. Zip Code 254	11		10g. Citizen of What U.S.A	
980	pormit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. Department of Heelih and Heelih and Heelih and Hygiene. Department of Heelih and Heelih and Hygiene. Department of Heelih and Hygiene.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married XXVidowed 4 ☐ Divorced	12. Was Deceder Armed Force 1 Yes XI If Yes, Give Year or Dates	s? XINo		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2XX	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Black, Wi	nencan Indian, hite, etc. White
Manjand 21215,0036	d within 72 hygiene. ar then "natu	Completed	15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12) 12		or 5+)	(Give life. (lent's Usual Occup kind of work done 20 NOT use retired OMEMAKET	oation during most of wor d)	king	16b. Kind of Busines Own h	,
- Janet	uld be file Mental Hy Irked oth Itlc svsnt	To Be (17. Father's Name (First, Middle, Las Walter	C.		Barker		18. Mother's Nam Kathry		, <i>Maiden Sum</i> ame) S m	ith
20	and 2 sho eith and 1 127 is ma or trauma		19a. Informant's Name/Relationship John W. Hansrot							er, City or Town, State rings, WV	
Belt-imore	Pages 1 and of He nent of He nent of He nert of He nert of He nert of He nert of He nert or other ne		20a. Method of Disposition 1XD urial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		0	emetery, cren	sition (Name of natory or other place UMC Ceme:	tery 11/	Date 11/2007	20c. Location - City Great Ca	
1	permit. Departr Importa		21. Signature of Funeral Service Lice	insee	M005	22 H	Name and Addre elsley-Jo 5 Union	ss of Facility Ohnson Fu St., Berk	neral H selev Sp	ome, Inc.	25411–1855
Seath	Physician /Medical Examiner		23a. Part1. Ent - the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Preu	ed the death line.	h. Do not ente	er the mode of dyin	ng, such as cardiad	or respiratory a	rrest,	Approximate Interval Between Onset and Death
of Hans	ecuted and transit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq						
aulin 68760	ficate be executed physicien and stife burial-transit	dical		d .							
Helen Pa	= 0,00	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta at time of d	Ideath 3	Ectopic pregnancy Other (specify)	,		23d. Date of o	elivery Day Year
Ale rds P	w requires that been signed b	ed by Ph	Part II. Other significant conditions Congestive hea		but not res	ulting in the ur	derlying cause giv	en in Part I.		obacco use contribute	to the cause of death? Probably 4 □Unknown
Beco	The law receive has bee	Completed	dementa of	the Al	shew	mers	type		24a. Was autop perfo	rmed // death	autopsy findings available o completion of cause of essence of the cause of the cau
f Vita	ysician: Th iis certificete director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ №	Hospital: 1 ☐ Inpa	itient 2	ER/Outpatien	3 DOA Oth	26. Place of Dea		one dence 6 ☐ Other (Sp	pecify)
sion o	utsnding Ph death. ctor: After th y the funeral	Certification:	27. Manney of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not		njury Da <i>y Year)</i>	28b. Time of Injury	28c. Injur Wor M 1 🗆		28d. Describe I	how injury occurred	
Ö	To the Hospital or Attendia within 24 hours after death. To the Funeral birector: A completely filled in by the fu		4 Homicide determined	building,	etc. (Specifi	<i>(</i>)	eet, factory, office		City or Tou		
	ths Hosp nin 24 hou ths Fune	Medical	one)	hysician: To the bes miner: On the basis and manner	or examina	wledge, death tion and/or inv	estigation, in my o	pinion, death occu	rred at the time,	cause(s) and manner date and place, and d	ue to the cause(s)
	To Con	2	29b. Signature and title of certifier Cupture Kee					17451		Novembe	- 9,2007
_	3		30. Name and address of person who Cynthia Kuttner	completed cause of	death (Item	123a) (Type, I	Port Nu	rsing Ho	me 154	two-th A uryland 2	rtizan Street
	Sta Registr		31. Date filed (Month, Day, Year)		strar's Signa	ture	nels.				

DHMH 17 Rev 1/2001

ORIGINAL

			For State	State of M	larylan				lealth a Death	and M	ental H			007	37	133
		2	Regîstrar 1. Decedent's Name (First, Middle, Last			007	imou		- Cairi	Т	2. Date of I				3. Time	
	Physic	_	Chung			Hsu					Month Noveml	per	oay 4, 20	Year 007	6:05	\mathbf{A}^M
	/Medi Examii		4a Facility Name (If not institution, give Shady Grove Adven	street and number	ina		4b. City	, Town, or	Location o				4c. County			
			Center					ckvi					Mont	gome	ry	
	Funeral Director		5. Social Security Number 6. Se 1555-57-3271	X YM 2□F	ge (In yrs. i 92	last birthday) Yrs.	If Unde Months	Days	If Under: Hours	Min.	8. Date of E (Month, I Aug	Day, Yea	915	9. Birth Cou Chi		or Foreign
	w w		Usual Residence of Decedent 10a. State 10b. County		10c, City	y, Town or Lo	cation							1	10d. Inside (City Limits
	Maryla f sho ied at	ō	Maryland Montgomen	rv	Gait	hersbu	ra									s 2K No
	r 28a- notif	rec	10e. Street and Number	- 3	Guit	.nersbu		p Code				10g. (Citizen of	What Cou	ntry?	
	th with	a	600 Poplarwood Pla	ace			20	877				Ur	nited	Stat	tes	
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?		Vas Dece f Yes, spe I □ Yes		ispanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto F	cify Yes or I Rican, etc.)	No-		ck, White,	can Indian, etc.	_
2-0	72 ho natur lical l	Completed	15. Decedent's Edu (Specify only highest grad	ication		16a. Deced	lent's Usu	ual Occupa	ation	t of workin	a a	16b.	Kind of B	usiness/In	dustry	
21	within lene. than " he Mec	nple.	Elementary/Secondary (0-12)	College (1-4or	5+)				during mos)	CO WOTAL	<i>,</i> g	_	_	~		
N	be filed w ntal Hygie id other ti event, th	S	17. Father's Name (First, Middle, Last)			Polic	e UI	ricer		or's Name	(First, Mida		en Surnan		ement	
anc	d be fental here) Be	Yu-Kui Hsu							Young		io, iviaiu	en ouman	110)		
Maryland	should trud Ment marked umatic e	ဥ	19a. Informant's Name/Relationship (T)	/pe. Print)		19b. Mailin	g Addres	s (Street a			I Route Nun	nber, Cit	y or Town,	State, Zij	o Code)	
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Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licens	see Uu		22	. Name a	nd Addres	s of Facilit	ty De	Vol F Lve, G	uner	al H	ome,	•	
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	/Medical Examiner		resulting in death)	Due to (or as	s a consequ	uence of):										J -
	ted %	nìner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	bDue to (or as	s a consequ	uence of):										
,0928	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transif	dical Examiner	that initiated events resulting in death) Last	Due to (or as	s a consequ	uence of):										
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P.O. I	res that the designed by the a	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of d	eath 5	Other (s	pecify)							Duy	1001
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900	ie law requir has been si je 2 should b	plete	Diabetes Melli	tus							24a. Wa	as an topsy	24b.	Were auto	opsy finding	s available
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or \	Physic this c al dire	2	1 1 1es 2 🔀 140	Hospital: 1 ☐ Inpat		ER/Outpatien			4 X Nu		me 5□Re				fy)	
ou c	After une	jo	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ay Year)	28b. Time of Injury	М	28c. Injur Worl	yat ⟨? Yes 2⊟∣		28d. Describ	e how ir	ijury occur	red		
Division or	or Attendifter death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of in building, e	ijury - At ho etc. <i>(Specif</i>)	ome, farm, str					8f. Location City or 7	(Street own, St	and Numb ate)	ber or Rur	al Route Nu	mber,
_	To the Hospital or Attenwithin 24 hours after death To the Funeral Director; completely filled in by the	Medical Co	29a. Certifier (Check only one) 1 Certifying Phy Medical Exam	rsician: To the bes iner: On the basis and manner s	of examina	wledge, death tion and/or in	occurre vestigatio	d at the tir	ne, date ar pinion, dea	nd place, a ath occurre	and due to the	ne cause e, date	e(s) and mand place,	anner as s	stated. to the cause	r(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				29	c. License	e number			29d. l	Date signe	ed (Month,	Day, Year)	
	2		ANG-					D2	8656			No	vembe	er 5,	2007	
-	ン		30. Name and address of person who co													
			Ravi Passi, M.D.,				oad,	Rock	ville	e, Ma	ryland	1 20	850			
	Sta Regist		31. Date filed (Month, Day, Year)		trar's Signa	ture	and?	R								

			For State	State	of Marylai	•	artment of rtificate of	Health and Death	, ,	iene eg. No. 🤈 🎧 I	0.7	07000
П	м	4	Registrar Decedent's Name (First, Middle)	dle, Last)					2. Date of Dear	th 2 U	U-/-	3. Time of Death
Ap.	Physici /Medic		Elizal	oeth Holl	and				Novembe		Year)7	1:28 A ^M
Ag.	Examir		4a. Facility Name (If not instituti	on, give street and n	umber)		4b. City, Town,	or Location of Deat	h	4c. County o	f Death	
	Light of the state of the state of the state of the state of the state of the state of the state of the state of	2	Prince Georges 5. Social Security Number	Hospital				sville If Under 24 Hrs	9 Date of Birth	Prince		
11 200	Funeral Director		226-18-8921	6. Sex 1 M 2	7. Age (III yis	82 Yrs.	Months Days			Year)	Coun	lace (State or Foreign try) ginia
			Usual Residence of Decedent						000. 20	, 1923	VII	ginia
	inylan ihow	_	10a. State 10b. Count	ty	10c. C	ity, Town or Lo	ocation				1	Od. Inside City Limits
	ne Ma 8a-f s	Director		N/A		Washin						1 XXYes 2 □ No
	a or 2 be n		10e. Street and Number				10f. Zip Code	010	1	0g. Citizen of W	hat Coun	try?
	leath ns 23 must	Funeral	8024 Eastern .	12. Was De	cedent Ever in l	J.S. 13.		012 Hispanic Origin? (S	Specify Yes or No-	U . S .	- Americ	an Indian,
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	by Fun	1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed F arried 1 ☐ Yes If Yes. G	orces? 2. 2¼ No Sive		If Yes, specify Cu 1 ☐ Yes 2 🛛 No	Hispanic Origin? (S ban, Mexican, Puer Specify:	to Rićan, etc.)	Black Specify:	Afri	can
8	hour stural	ed	15. Decede	ent's Education		16a. Dece	dent's Usual Occu	pation		16b. Kind of Bus		lustry
215	d within 72 housene. r than "natu the Medical	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed	(1-4or 5+)	(Give	kind of work done DO NOT use retir	e during most of wo	rking			•
21	filed with Hygiene other the	Com	6			House	ekeeping			Priv		
Maryland 21215-0036	be d o	Be	17. Father's Name (First, Middle	e, Last) Unkn	own			18. Mother's Na	me (First, Middle, i	Maiden Surname) Un	known
Z	ges 1 and 2 should be it of Health and Mental If item 27 is marked o or other traumatic eve	ပ	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailii	na Address <i>(Stree</i>	t and Number or R	ural Route Number	r. City or Town. S	State Zin	Code)
Ma	and 2 sho ealth and n 27 is ma		Barbara Holla		hter		-		W. Washi	-		,
Ē,	s 1 and 2 of Health item 27 i		20a. Method of Disposition		20b.	Place of Dispo	osition (Name of matory or other pl	17		20c. Location - C		
m	Pages nent of I ant: If its ary or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other				d Cemete:	i	7, 2007	Washing	gton	. D.C.
Baltimore,	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service	e Licensee	lush			ress of Facility	AcGuire F	uneral S	Serv	
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that	caused the dea			-			. ال و1.	Approximate
	Physician ¹		shock, or heart failure. Li Immediate Cause (Final disease or condition									Interval Between Onset and Death
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P.0	requires that the de neen signed by the a hould be detached t		Part II. Other significant condi	tions contributing to	death but not re	sulting in the u	nderlying cause g	iven in Part I.	23e. Did to	bacco use contri	bute to th	ne cause of death?
or Vital Records,	w requires to been signer should be	d by							1 □ Y	es 2□No	3 ☐ Prob	ably 4 🔼 Unknown
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Re	0 7 0	mo					·		autops perfor 1 Yes	med? de	eath?	npletion of cause of 2□ No
ital		Be C	25. Was case referred to medic examiner?	cal				26. Place of De	ath (Check only or			2010
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		ino in	27. Manner of Death 1 ☑ Natural 5 ☐ Pend	fing (Ma	e of Injury onth, Day Year)	28b. Time o Injury	W W		28d. Describe he	ow injury occurre	ed	
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	To the Hospital or Attentwithin 24 hours after death Vo the Funeral Director: completely filled in by the	Medical C		ring Physician: To the								
	To the within 2 To the comple	Mec	29b. Signature and title of certif		anier stateu.		29c. Licer	nse number	2	9d. Date signed	(Month,	Day, Year)
	7		Late	Mite	710		DO	026024		Nov. 1,	2007	7
)		30. Name and address of person	on who completed car	use of death (Ite	em 23a) (Type,					2007	
			Lester Miles	M.D. 649	0 Lando	ver Ro	ad, Land	over, MD				
)	Sta Registi		31. Date filed (Month, Day, Yea	2007	eğistrar's Sigr	K M	antes					

			Please Type or Print in Black indelible in			•	
		_	State of Maryland / Department of		lental Hy	giene	
			1 - State Registrar Certificate of	f Death		Reg. No. 2	37339
	Dhamini	%Q	1. Decedent's Name (First, Middle, Last)		2. Date of De Month	ath Day Year	3. Time of Death
	Physicia /Medic	74	Michael Brian Hogan		Nov	4 200-	
	Examin	_		, or Location of Death	·	4c. County of Dea	
	in the second second second		Howard Conty General Hyphal	Columbi			Ald
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea Months Days		8. Date of Bir (Month, Da	9. Bir y, Year) 1940 Cal:	thplace (State or Foreign ountry)
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	and w	}	Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	f sho	ō	Nevada Carson Carson City				1 √ Yes 2 No
	the N 28a-	Director	10e. Street and Number 10f. Zip Code	e		10g. Citizen of What Co	ountry?
	with taor t be		2309 Glenn Drive 89703			USA	
	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show snt, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of	of Hispanic Origin? (Sp Suban, Mexican, Puerto	ecify Yes or No	- 14. Race - Ame	
_	fter c r iter niner	표	1 Never Married 2 Married 1 Tyes 2 M No		Rican, etc.)	1	
5-0036	urs a al'', o Exam	þ	If Yes, Give 1 ☐ Yes 2 💢 No. 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	lo Specify:		Specify: Wh	ite
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7	gen wil	5	4 Pharmacist			Pharmacy	
2	e file al Hy t oth	Be Completed	17. Father's Name (First, Middle, Last)			, Maiden Surname)	
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_	and ealth n 27		Freida S. Hogan/Wife 2309 Glenn D			, NV 89703	
9	iges 1 nt of H : If Iter		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p		Date	20c. Location - City or	
Ē	Pages ment of I ant; If Its ury or o		4□Donation 5□Other (Specify) Chesapeake Crema		06/07	Beltsville	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service-Licensee 22. Name and Add Going Hom	dress of Facility ne Crematic	n Servi	ice P.O. B	ox 784
_	<u>ਜੂਹ ਦਾ ਭ</u>		Devent & to the MO1251 Beverly I	. Heckrott	e. P.A.	Clarksvil	le, MD 21029
			23a. Part1. Enter the obsesse, or complications that caused the death. Do not enter the mode of d shock, or heart failure. List only one cause on each line.	dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	CAIdia	14501	N duly	Chiset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Attendisciple for as a consequence of): Due to (or as a consequence of): Deguentially list conditions.				
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1	pg tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that bittled are after the conditions).				
	ecute and trans	Kam	resulting in death) Last Due to (or as a consequence of):				
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289			d				
×	The law requires that the death certificate tte has been signed by the attending phys hage 2 should be detached for use as the	Physician/Media	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of de	Nisons
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1	that ted by		Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Did 1	tobacco use contribute t	to the cause of death?
Vital Records,	w requires that been signed b should be deta	d by			1 🗆	Yes 2. No 3□F	Probably 4 ☐Unknown
ö	v req been shoul	Completed			24a. Was	an 24h Were s	utopsy findings available
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DIVISION OF	Atten deat ctor: y the	fica	3 Suicide 6 Could not be determined determined 28e. Place of injury - At home, farm, street, factory, office	ce		Street and Number or F	Rural Route Number,
2	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or 10	wn, State)	
	spita nours nera y fille		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the				
	To the Hospital or Attending Physiclan: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in m and manner stated.	ny opinion, death occu	rred at the time	, date and place, and du	ie to the cause(s)
	To the within	M	29b. Signature and title of certifier 29c. Lice	ense number		29d. Date signed (Mor	nth, Day, Year)
			If mo Ex Allerdar V	14132	0	NOUY	2007
(5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1	n 1	,	
T.	> ad		Lowald Marry no 5755 6ds	V4 6	Olumb	11+ Md	21044
	Sta		31. Date filed (Month, Day, Year) NOV 0 7 2007 32. Registrar's Signature			,	,
	Registr	ar	MUV U 7 COUT MERCE D. Appendix				
DL	IMH 17 Doy 1/2	001					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 1905 M 10 26 2007 /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner 205 Pauline Court Arnold Anne Arundel 8. Date of Birth (Month, Day, Year 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months Hours 185-24-5691 1 M 2 F 74 May 11, Director 1933 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits MD Anne Arundel 1 ☐Yes 2 X No Funeral Director Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 205 Pauline Court 21012 USA ms 23a of Health and Mental Hygiene.
item 27 Is marked other than "natural", or items:
other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian. Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No Baltimore. Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Aerospace Elementary/Secondary (0-12) 12 College (1-4or 5+) Computer Operator Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be Franklin Geesev Elizabeth (UNK) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 205 Pauline Court, Arnold, Maryland 21012 Jeffrey H. Allen/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Oct 31, 1 ☐ Burial 2 【XCremation 3 Removal from State Metro Crematory Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 2007 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1☐ Yes 2XNo 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760,

neral Director: A filled in by the fu

within 24 hours a completely

Medical

State Registrar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Month, Day, Year)
OCT 3 1 2007

6 Could not be

determined

3 ☐ Suicide

29a. Certifier

4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

JOHN	D.	IMER
07-07853		Pleas

NK UNK	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.	2007 3734
Physician Medical Examina	Redistrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death About Pay	3. Time of Death Year 1117 hrs
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Funeral Director		YYY) 9. Birthplace (State or
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hours af	Tor Dates:	f Business/Industry
136 Thin 72 ne. Than "	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17b. Kind of work done during most of working life. DO NOT use retired) 17cket Master 17cket Master 17cket Master 17cket Master 17cket Master 17cket Master 17cket Master	rak
21215-0036 and be filed within 72 hours Mental Hygiene. marked other than "natur e event, the Medical Exam	17. Father's Name (First, Middle, Last) John Imer 18. Mother's Name (First, Middle, Maiden Surna Ruth Grisso	ame)
MD 2's bould 2 should alth and M m 27 is ms aumatic er	 19a. Informant's Name/Relationship (Type, Print) Michael S. Slater/ Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or 24033 Sugar Cane Lane, Gaither 	
2 = 5 = 5	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, remainly or other place) 20c. Location of Disposition (Name of cemetery, remainly or other place) 20c. Location of Disposition (Name of cemetery, remainly or other place) 20c. Location of Disposition (Name of cemetery, remainly or other place) 20c. Location of Disposition (Name of cemetery, remainly or other place) 20c. Location of Disposition (Name of cemetery, remainly or other place) 20c. Location of Disposition (Name of cemetery, remainly or other place) 20c. Location of Disposition (Name of cemetery, remainly or other place) 20c. Location of Disposition (Name of cemetery, remainly or other place) 20c. Location of Disposition (Name of cemetery, remainly or other place) 20c. Location of Disposition (Name of cemetery, remainly or other place) 20c. Location of Disposition (Name of cemetery, remainly or other place) 20c. Location of Disposition (Name of cemetery, remainly or other place) 20c. Location of Disposition (Name of cemetery, remainly or other place) 20c. Location of Disposition (Name of cemetery, remainly or other place) 20c. Location of Disposition (Name of cemetery, remainly or other place) 20c. Location of Disposition (Name of cemetery, remainly or other place) 20c. Location of Disposition (Name of cemetery, remainly or other place) 20c. Location of Disposition (Name of cemetery) 20c. Location of Disposition (Name of cemetery) 20c. Location of Disposition (Name of cemetery) 20c. Location of Disposition (Name of cemetery) 20c. Location of Disposition (Name of cemetery) 20c. Location of Disposition (Name of cemetery) 20c. Location of Disposition (Name of cemetery) 20c. Location of Disposition (Name of cemetery) 20c. Location of Disposition (Name of cemetery) 20c. Location of Disposition (Name of cemetery) 20c. Location of Disposition (Name of cemetery)	ion-City or Town, State
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Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. For the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transition. To Bo Computed, the Division of Madrical Experience of the control of the Deviction of the control of the control of the Division of the control	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (Specify)	le of delivery th Day Year
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S, P.O. uires that the signed by Id be detacled by Ed.	1 Yes 2 No	3 Probably 4 V Unknown
Division of Vital Records, tal or Attending Physician: The law require stafer death. al Director: After this certificate has been sited in by the funeral director, page 2 should be refification: To Be Commission	24a. Was an autopsy performed?	4b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
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Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		
		signed (Month, Day, Year) 9, 2007
	30. Name and address of person who completed cause of death (It/m 235) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Stat Registra	1/2 1 / 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 13 Day ٧. **Physician** GLADYS JOHNSON 11 2007 /Medical City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore Franklin Square Rosedale Hos Dital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN. 17, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Days 1 □ M 2/XF 84 WEST VIRGINIA 235-28-3419 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Infinoctant: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified any injury or other traumatic event, the Medical Examiner must be notified. 1 ☐ Yes 2XXVo Director MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21220 1533 ALDENEY AVENUE Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Lohndon Glady S Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME **HOMEMAKER** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MADELINE UNDERDONK THOMAS J. SHIPPER 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1533 ALDENEY AVE., BALTIMORE, MD 21220 DARLENE BURNS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition NOVEMBER 1 Burial 2 □ Cremation 3 Removal from State MARTINSBURG, WV GREEN HILL CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 17, 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 Blown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cerebrovascular **Physician** Hemorrhaa disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Dav in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9☐Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 08 2 No 3 Probably 4 ☐Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical examiners 26. Place of Death (Check only one) 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) No No 2 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Marketifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral is the

> 3 State Registrar

Majid Cina, 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

MD, 9000 Franklin Square Drive, Baltimore, MD 32, Registrar's Signature

29c. License number

D63054

29d. Date signed (Month, Day, Year)

November 13, 2007

				d / Department of Health and Me	ental Hygien	ne	
			1 = State Registrar	Certificate of Death	Reg. N	10.2007 27212	
п	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Jime of Death J	
	/Medi		Dianne P. Johnson 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		19 2007 0616 M	
7	Examir	ıer	Memorial Hospital	Easton	4	Talbot	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. Ia	ast birthday) If Under 1 Year If Under 24 Hrs. 8	B. Date of Birth	9. Birthplace (State or Foreign	
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	pur »		Usual Residence of Decedent 10a. State 10b. County 10c. City.	, Town or Location		10d. Inside City Limits	
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	the 128a-notifi	Director	Md. Queen Annes C	Centreville 10f. Zip Code	10a. C	Citizen of What Country?	
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98	or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 🗹 No Specify:	ican, etc.)	Black, White, etc.	
21215-0036	d within 72 hours after death with the Maryland Jene. r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at	ed by	3 ☐ Widowed 4 ₺ Divorced Year or Dates:	16a Decadosta Havel Convention	405	Black	
15	in 72 n "na Adic	Completed	(Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	7	Kind of Business/Industry	
212		E	Elementary/Secondary (0-12) College (1-4or 5+)	Line Worker		mpbell Soup	
pu	al Hyger of the vent,	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (en Surname)	
yla	should book and Menta	인	Robert Pritchett	Bertha	Rozie	r	
Maryland	12 shoul h and M is marl raumati		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rural		,	
	s 1 and 3 Health Item 27 other tr		Edward Cheers / Son	114 Choptank Ave., E		d . 21601 Location - City or Town, State	
altimore,			1 ★Burial 2 □Cremation 3 □Removal from State	metery, crematory or other place)			
ij	permit. Page Department Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) Ch 21. Signature of Funeral Service Licenseen	esterfield 10-27	<u>-07 Ce</u>	ntreville,Md th FuneralHome	
ñ	Depar Impol any ir		Quall Fork	426 Dover St., Eas			
1			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.			Approximate Interval Between	
-	Physician		Immediate Cause (Final disease or condition	intracerebul hen	orthe	Onset and Death	
	/Medical Examiner		resulting in death) Due to (of as a consequence)	ence of):	1	- 1 trys	
į.		7	Sequentially list conditions, if any, legaling to introduce	2wr		zens	
	nsit	mine	Cause (Disease or injury	in the Uty.			
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89	ng ph as th		IF FEMALE:				
Вох	leath certifi attending for use as	lan/	23b. Was decedent pregnant in the past 12 months?			23d. Date of delivery	
0	at the death cert I by the attending stached for use a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of dea	ath 5 Other (specify)		Month Day Year	
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ita	yslcian: The is certificate hidirector, page	BeC	25. Was case referred to medical examiner?	26. Place of Death (1□ Yes 2♥↑ Check only one)	lo 1 □Yes 2 □ No	
۲ >	hysic his ce	일	Hospital:	R/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence	6 ☐Other (Specify)	
n o	ding Ph h. After th funeral		1 ☑ Natural 5 ☐ Pending (Month, Day Year)	Injury Work?	d. Describe how inj	ury occurred	
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Division or Vital Records,	l or A after Direc I in by	Certification:	4 Homicide determined building, etc. (Specify)	ne, farm, street, factory, office 28	City or Town, Sta	and Number or Rural Route Number, te)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director. p		29a. Certifier 1 Certifying Physician: To the best of my knowl	ledge, death occurred at the time, date and place, an	d due to the cause((s) and manner as stated.	
	he Ho in 24 I he Fu pletel	Medical	(Check only one) 2 ☐ Medical Examiner : On the basis of examination and manner stated.	on and/or investigation, in my opinion, death occurred	l at the time, date a	nd place, and due to the cause(s)	
	Neith with Com	Σ	29b. Signature and title of pertifier	29c. License number	_	ate signed (Month, Day, Year)	
)			I Come	64043	0	to ber 17, 2007	
	4		30. Name and address of person who completed cause of death (Item 2 ρ	23a) (Type, Print) -19 S. Ates higher St.	FACT	to ber 17, 2007	
	Sta	e_	31. Date filed <i>Month, Day Year</i> 32. Registrar's Signatu	ire . was ny un ot.	C10101	1001	
	Registra	ar	31. Date filed (Month, Day Year) 32. Registrar's Signatu	Sports"			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NOVEMBER 01, 2007 4:45A GENEVA B. JONES /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES SAINT THOMAS MORE NURSING & REHAB HYATTSVILLE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2XX NORTH CAROLINA 578 20 9305 89 DEC. 11, 1917 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County iral", or items 23a or 28a-f show Examiner must be notified at XXYes 2 □ No Director PRINCE GEORGES HYATTSVILLE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 20782 6000 SARGENT ROAD #210 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes **2\lambda**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: BLACK þ 3\ Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) event, the Medical rthan Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Many Injury or other traumatic event, the Many Injury or other traumatic event, the Many Injury or other traumatic event, the Many Injury or other traumatic event, the Many Injury or other traumatic event, the Many Injury or other traumatic event, the Many Injury or other traumatic event, the Many Injury or other traumatic event, the Many Injury or other traumatic event. PRIVATE SALES ASSOCIATE 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LENA BROWN COLUMBUS JONES P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11403 RHODE ISLAND AVENUE BELTSVILLE, MD 20705 19a. Informant's Name/Relationship (Type. Print) WILLIAM JONES / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XIX Burial 2 Cremation 3 Removal from State MARYLAND NATIONAL CEM. 11/07/07 LAUREL, MD 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, 4308 SUITLAND ROAD SUITLAND, MD 20746 Signature of Funer I Service Licenses INC. Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final eachRAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner TRICRIOSCIEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Examin certificate be executed Due to (or as a consequence of): Box 68760 attending physiciar Physician/Medical as the l nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? /es 22No 1□ Yes 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Be 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🔲 Yes Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident hours after death uneral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide ö within 24 hours a To the Funeral C Hospita Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated

State Registrar

31. Date filed (Month, Day, Year NIOV 0 6 2007

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) D01852

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				State of Ma	ryland		rtment of		and Mental H	lygiene Reg. No 2	דחר	3731.6
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	Examir		4a. Facility Name (If not institution, giv 1062 Double Gate	•					wn, or Location of De sonville		Aruno	ie1
	Funeral Director		5. Social Security Number 6. S 158-56-4267	Sex 7. Age	(In yrs. las		If Under 1 Ye Months Day		Min. (Month.	Birth <i>Day, Year)</i> Der 31,1	9. Birth Cou	place (State or Foreign ntry) ew Jersey
	e Maryland 8e-f show tiffed at	ctor	10a. State 10b. County Vermont Windsor			rown or Loc e Riv	er Junc	tion				10d. Inside City Limits 1 ☐ Yes ※XXNo
	with th	Dire	10e. Street end Number				10f. Zip Code			10g. Citizen o		ntry?
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other than "netural", or itams 23a or 28e-f show any injury or other traumatic event, the Madical Examinate must be muitibal at once.	by Funeral Directo	1298 Nea1 Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			0500 as Decedent of Yes, specify Co	f Hispanic Ori uban, Mexicar	gin? (Specify Yes or 1, Puerto Rican, etc.)	USA No- 14. R B	ace - Americ lack, White,	
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, Mai y	and 2 shot ealth and N m 27 is mai		19a. Informant's Name/Relationship (Douglas L. Johnson		1	.298 N	eal Roa	d Whit	er or Rurel Route Num e River Ju	unction,	VT	05001
	. Pages 1 tment of H tant: If iter jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	y)		s Cre	tion (Neme of atory or other p matory		1	_	ter,	Maryland
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	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	plications that caused the cause on each line cause on each line a.	he death.	Do not enter	the mode of d	ying, such as	cardiac or respiratory	arrest,	1	Approximate Interval Between Onset and Death
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	ien: The la artificate ha ctor, page	Be Com	25. Was case referred to medical examiner?					26. Place	1 [of Death (Check onl	Yes 2 No	M 10	Yes 2 No
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Amend #1.perMD.g873, 11/30/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Ozra Darbandi Khakzadeh 2. Date of Death **Physician** Month Day 7:50 PM Khak za och) tuber スフガー 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kondalls town

If Inder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Northwest Huspo, tal Baltimore Center 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F 559-95-9089 Director Sep.16, Tehran, 1936 Iran Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ∐Yes 2**X** No Director Maryland Baltimore Owings Mills 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21117 USA 9563 Ashlyn Circle Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 is marked other thin any injury or other trainmants. 12 Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abbas Darbandi Zahra K 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mansour Khakzadeh (Husband) 9563 Ashlyn Circle, Gwings Mills, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State National MemorialPark 10/29/07 Falls Church, VA 22042 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service icense National Funeral Home 7482 Lee Hwy, Falls Church, VA 22042 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NA daus /Medical Due to (or as a consequence of): Examiner Occiusión Mural Comp Ind Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ② No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No ariel from llation 24a. Was an autopsy performed? Yes 2 1 No has 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Thepatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient Certification: To 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of contifier 29c, License number 29d. Date signed (Month, Day, Year)

State

Registrar

DHMH 17 Rev 1/2001

SUDI

32 Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

GARDIE

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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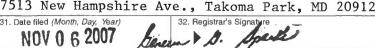
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Funeral	-	5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday)	If Under 1	Year	If Under 2	24Hrs.	8. Date of Birt	h(MM/DD/YYYY)		e (State or
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Hyge	اد	, ,		DV							naiden Surname)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f she injury or other trannatic event, the Medical Examiner must be notified at once		LESLIE CLIFFO 19a. Informant's Name/Relation			19b. Maili	na Address (SANDR and Number			ber, City or Town	. State. Zip (Code)
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ision of Vital Records, P.O. Box 6876. Attending Physician: The law requires that the death certificate death. ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the transmission.		23b. Was decedent pregnant in past 12 months?	the	ive birth		etal death	3	Ectopic p	regnan	су	Month	Day	Year
nth cer	١ڠ	1 Yes 2 No 9 U	-	Pregnant at time	of death 5	Other (Specify)				1		
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P.O. es that the igned by be detacl	Ş	Part II. Other significant cond	litions contribut	ing to death but	not resulting in the	underlying ca	ause giv	ven in Part	1.		obacco use contrib		-
S, F.													
ord w req is bee										24a. Was autop	sy pr	rior to comple	findings available etion of cause of
Reco	Completed									1 Yes		eath? ✔ Yes	2 No
of Vital Records, ng Physician: The law require wher this certificate has been si meral director, page 2 should be	ne l	25. Was case referred to medic				26.		of Death (C	heck or	nly one)			
Vit.	0	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2 ER/Outpatie	nt 3 DOA	4 0	Other:	Nursing	Home 5	Residence 6	Other:	
n of Viding Physical After this funeral direction		27. Manner of Death	28a.	Date of Injury Month, Day,Year)	28b. Time o	~		at Work?		28d. Describe I	how injury occurre	d	
Sion Attendi death. crtor: /	일			1 11/11/2	007 FNd 9:4	30 am	1Ye	es 2 X N	₀ u	nk			
Division tal or Attendi rs after death. al Director: /	erification		uld not be 28e.	Place of Injury	- At home, farm, st	eet, factory, o	ffice bui	ilding, etc.	2	28f. Location (\$	Street and Numbe	r or Rural R	oute Number, City Legheny, M
Divis	١ -	4 Homicide	termined (Spe	ecify) car	mpsite				G	reenridg	ge State Fo	rest Ca	mpsite,
e Hos 24 h e Fun		(Chock only	-		owledge, death occ								()
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	۵L	2 🔻	and man	asis of examina ner stated	tion and/or investig				irred at	trie time, date			
	≥ [29b. Signature and title of certi	fier					number			29d. Date signe	,	Pay, Year)
		Tamit Sair	Hall, M				D.C.M	1.E.			November '	13, 2007	
	t	30. Name and address of person			,								
		Pamela É. Southall,		ant Medical		11 Penn S	treet,	Baltimo	re, MI	D 21201			
Sta	te	31. Date filed (Month, Day Yea	2007	2 Registrar's S	ignature	rolle 3							
Registra	ध	1404 T	5 2001	A CONTRACT	See See	- Charles							

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State NOV 0 6 2007 Registrar

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D050545

Godswill O. Okoji, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 3,2007 Julia Ann Kasubick 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CHARLES ATAJA MEDICAL CENTEK LA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, Days 1 M 2 XF 84 178-30-2580 Nov.15,1922 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Pennsylvania Houtzdale 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 600 Sue Street 16651 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify Specify: 3 ₩Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Her Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Moscollic Mary Michnowicz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvester T. Kasubick Son 6075 Chapmans Landing Road, Indian Head, Md. 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 9 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Brisbin, Pennsylvania St. Barbara's Catholic Church M00668 Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, SEPSIS Due to for as a consti 21. Signature of Funeral Service Lie 23a. Part1. Enter the of shock, or heart fa Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONI'A Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Examine

Physician/Medical

9

Completed

Be

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Certification:

Medical

Physician

/Medical

Examiner

Funeral

Director

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Director

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Completed

an "natural", or items 23a or 28a-f sh Medical Examiner must be notified

Department of Heatht and Mental Hygiene, Important: If item 27 is marked other than any Injury or other traumatic event, the Me once.

Pages 1 and 2 should be

permit.

filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed and burial-tra attending physician for use as the buria ed by the a signed I has page 2

Box 68760.

P.0.

or Vital Records,

Division or Attending

certificate this after death.

I Director: After to d in by the funera

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autonsy perform 1∏ Yes 26. Place of Death (Check only one)

2007

Hospital: 28a. Date of Injury Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

00061652

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PEMBROOK SQUARE SUITE 304 WALDORF.

State Registrar 31. Date filed (Month, Day, Year) NOV 0 6 200

KATYAL

determined

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 | Homicide

11350 32. Pregistrar's Signature

within 24 hours aft

To the Funeral Di

completely filled in

Baltimore, Maryland 21215-0036 Lewis, Moses

				ack Indelible Ink. Ensure All of Department of Health and Me	-				
٨٠	nd #22,	F	1 _ State	Certificate of Death		gien 26 0 0 7 3 7 3 5 1			
A			H Registrar TCHD 10/25/07 pha 1. Decedent's Name (First, Middle, Last)		. Date of Dea				
	Physici /Medic		Moses Lewis	Ĉ	ctober	- 19 2007 1101 AM			
	Examin		4a. Facility Name (If not institution, give street and number) DOCCHESTER GENERAL HOS	SPita 4b. City, Town, or Location of Death		4c. County of Death Dorchester			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last $418-09-4442$ 93	t birthday) If Under 1 Year If Under 24 Hrs. 8	Date of Birth (Month, Day 02-09-	9. Birthplace (State or Foreign			
			Usual Residence of Decedent			10d. Inside City Limits			
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exprinent mast be rediffed at	Director	Md. Dorchester C	rowm or Location Lambridge		1 P Yes 2 □ No			
	with the or 2	Dire	10e. Street and Number	10f. Zip Code 21613		10g. Citizen of What Country? USA			
	death ms 23	Funerai	619 Cross Street 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specif	fy Yes or No-	14. Race - American Indian,			
9	2 should be filed within 72 hours after death wi and Mental Hygiene. Is marked other than "natural", or flems 23a raumatic evant, the Medical Exprired mast b	Fun	1 Never Married 2 Married 1 See 1 No	If Yes, specify Cuban, Mexican, Puerto Ri	can, etc.)	Black, White, etc.			
5-0036	ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	7		Specify: Black			
15	n 72 h	Completed	(Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	,	16b. Kind of Business/Industry			
2121	filed within Hygiene. other then "	ошь	Elementary/Secondary (0-12) College (1-4or 5+)	Janitor		Factory			
	be filed htal Hyg ed otha evant,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (I	First, Middle,				
ylaı	should be nd Mental marked o	To	David Lewis,Sr.	Bertha		lmes			
Maryland	12 sh h and 7 la m traum			19b. Mailing Address (Street and Number or Rural F		CERT OF STORY SURF			
	1 and 2 Health tam 27		Mary Alice Starkes, Niece 20a. Method of Disposition 20b. Place	123 Whippoorwill, Lr. e of Disposition (Name of Dat		20c. Location - City or Town, State			
DE L	Pages nent of h int: If its iry or of			thel Cemetery 10-26	5-07	Cambridge, Md.			
Baltimore,	# 문란들 .		21. Signature of Funeral Service Licensee	_ ,		itth Funeral Home			
<u> </u>	Depa Impo any ii		Quisell of ork	524 Race St., Ca	ambrī ^m	lg€,Md.21613			
	Physician /Medical		23a. Part1. Enter the disease, or complications that ceused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		respiratory arr	est, Approximate Approximate Interval Between Onset and Death			
	Examiner		Due to (or as a consequer	ice of):					
		Jer	Sequentially list conditions, if any, leading to immediate across Eater Le	nce of):					
	executed n and ial-transit	Examiner	cause. Enter Underlying Cause (classes or injury that initiated events c.						
90,		_	resulting in death) Last Due to (or as a consequent	ice of):					
6876	cate b physic	dica	d						
O. Box (The law requires that the death certificate be the has been signed by the attending physicia age 2 should be detached for use as the but	Physician/Medical	/sician/Me	/sician/Me	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
ط	res that the digned by the be detached	y Ph	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death?			
rds,	quires in sign	Completed by	PLEWAR OFFISWN		1 🗆 Y	es 2 No 3 Tobably 4 Unknown			
Record	law requir as been si 2 should	piet	CERSBRAL HYBROUA		24a. Was a				
æ		Com	HTN		perfor	med? death? 2 No			
Vital	Physician: The this certificate har director, page	Be	25. Was case referred to medical examiner?	26. Place of Death (
of	두 두 교	: To				ence 6 Other (Specify) ow injury occurred			
	nding Phy th. : After thi s funeral	ition	1 ☐ Aural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury Work? M 1 ☐ Yes 2 ☐ No		,,			
Division	Hospital or Attanding 24 hours after death. Funaral Diractor: After tely filled in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	a, farm, street, factory, office	f. Location (S City or Tow	treet and Number or Rural Route Number, m, State)			
	To the Hospital or Attanowithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle and manner stated.	edge, death occurred at the time, date and place, an n and/or investigation, in my opinion, death occurred					
	To the within 2 To the complet	Σ	29b. Signature and the of certifier	29c. License number	2	29d. Date signed (Month, Day, Year)			
	1		1/4/ hrev	- MD D0065107		10/22/2007			
	2		30. Name and address of person who completed cause of death (Item 2:	3a) (Type, Print) 503A Muir	SV 1	2111 A. mh 211-12			
٠	Sta	to	31. Date filed (Mapth Day, Year) 107 22. Registrar's Signatur		011	CLOUN CILLI CONTACT			

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 6:30 P.M Patricia May Leith October 30, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 217 Booth Street, # 327A Gaithersburg Montgomery If Under 1 Year If Under 2 Months Days Hours 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 ☐ M 2 🗙 F Director 579-48-6508 73 April 23,1934 Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits show "natural", or items 23a or 28a-f shov dical Exaπiner must be notified at 1K Yes 2 □ No Director Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20878 United States 217 Booth Street, # 327A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No 2 Specify. Specify: 3X Widowed 4 ☐ Divorced White Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Loveless Mildred Mary Jennings Richard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 10007 Puritan Way, Damascus, Maryland 20872 Susan L. Billig/Daughter or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Metropolitan Crematory 10/31/2007 Alexandria, Virginia 4 Donation 5 Dother (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 Days a. Myocardial Infarction /Medical Due to (or as a consequence of) Examiner 2 Days Congestive Heart Failure Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine law requires that the death certificate be executed physician and stranger the burial-tranger Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending phore IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9☐ Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Chronic Kidney Disease Stage IV 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 XResidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No ours after death. Ieral Director: A filled in by the fu 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29b. Signatule and title of certifie 29d, Date signed (Month, Day, Year) D0040201 October 31, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Farzad Assar, M.D., Executive Park Court, Germantown, Maryland 20874 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 06

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Maryland		rtment of H tificate of L			ene g. No.	007	37353		
~			1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	n Day	Yeer	3. Time of Death		
	Physici /Medic		Lilyan Ruth	Leeper				10/31/2	-		4:25 AM M		
	Examin		4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. Co	unty of Oeati			
			11008 Fawsett Roa			Potomac	If Under Od Use	1	Mont	gomer			
	Funeral		5. Social Security Number 6. Sex	M 25FF	' birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Co	hplace (State or Foreign untry)		
	Director		230-48-9339 Usual Residence of Decedent	92	113.			11/4/19	14	Sou	th Carolina		
	show		10a. State 10b. County	10c. City, T	own or Loc	cation					10d. Inside City Limits		
	Mary -1 sh	ţo	Maryland Montgome	ry Co. Potom	120						1 ☐ Yes 2X No		
	1288 1288	irec	10e. Street and Number	y Co. 110com	iac	10f. Zip Code		11	og. Citizen	of What Co	untry?		
	h with	Funeral Director	11008 Fawsett Road			20854		1	J.S.A				
	deat	ner		12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-		Race - Ame Black, White	ricen Indian,		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or itame 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mont be redified at ODGE.	þ	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Yes 21 No	Specify:	Thous, Go.,		ecity: Wh			
Q K	72 ho	Completed	15. Decedent's Edu		6a. Deced	lent's Usual Occupa	ition Juring most of work		16b. Kind	of Business/	Industry		
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פ	d oth	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, M Sewell We		mame)			
<u>\frac{2}{a}</u>	ould Men varka	ပ္	Alphonso Barbour							01-1-	To Ondo		
ā	12 sh n and r is m		19a. Informant's Name/Relationship (Ty			g Address (Street a					up Code)		
ຜົ	and Health Im 27		Rebecca L. Locken 20a. Method of Disposition	(Daughter)		Fawsett Sition (Name of	Rd. Pot		208		Town, Stete		
Baltimore,	or of	- 1	1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	etery, crem	natory or other place					ch, VA		
	ntmer rtant njury		'4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	1		Mem. Par							
Ba	Depa Impo any i		21. Signature of Purietra Service Licens	1011		82 Lee H							
			23a. Part - Enter the disease, or compli	cations that caused the death							Approximate		
			shock, or heart failure. List only one course on each line.										
36	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Multiple	<u> </u>	nyelon	na						
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)	nsit	Examiner	daily, leading to interediate cause. Enter Underlying Cause (Disease or injury										
	and and all-tra	Exa	that initiated events resulting in death) Last	Due to (or as a consequen	nce of):								
8760,	cate be executed physician and the burial-transit			d									
Ø	tificating phy as the	edi											
Вох	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetel de		Ectopic pregnancy		23d. Date of delivery					
<u>m</u>	death e atte	icia	in the past 12 months?	4☐Pregnant at time of deat		Other (specify)				Month	Day Year		
P.O.	that the death cer ed by the attendin detached for use	hys	9 🗆 Unknown	9□ Unknown									
	aw requires that s been signed b s should be deta	эу Р	Part II. Other significant conditions cor	0: -0 (1)			en in Part I.				the cause of death?		
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ည္တ	aw re as be 2 sho	plet	of cerebrova	scular acc	ide	lent 24a. Was							
č	The late has	E						perform	ned? No No	death? 1 ☐ Yes			
ita	ian: rrtifica ctor.	Be C	25. Was case referred to medical examiner?				26. Place of Dea	th Check only on					
Division of Vital Records,	hysic nis ce I dira	10	1 ☐ Yes 2 ☑ No		VOutpatien	t 3□ DOA Othe	4 Nursing n	ome 5 Reside	nce 6	Other (Spe	city)		
0	ng Pl		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 28 (Month, Day Year)	Bb. Time of Injury	Worl		28d. Describe ho	w injury o	ccurred			
<u>S</u>	eath. or: A the fu	Certification:	2 Accident investigation			_	Yes 2 □ No						
Ξ	ter d irect irect	Ē	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and N , State)	lumber or Ru	ural Route Number,		
	urs at		The world value outsides	100000000000000000000000000000000000000	tion into		n symplets, excel	and the late of	Alle Superior				
	To the Hospital or Attending Physician: The lay within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only one)	ner: On the basis of examination	and/or inv	restigation, in my of	oinion, death occu	red at the time, d	ate and pla	ace, and due	to the cause(s)		
	thin 2 the mple	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	2	9d. Date s	igned (Mont	h, Day, Year)		
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			30. Name, and address of person who co	1 mo 16211		ernwood	RA #10	0 0.4	och.	MI	20817		
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DILL	ViH 17 Rev 1/2	001		-500	1								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** LAWSON EDITH ω /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months 1 M 2 T Director 414-42-9269 80 Jan. 25, 1927 Tennessee Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 Yes 2 No Director Maryland Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ms 23a 4R Laurel Hill Road 20770 USA Funeral th and Mental Hygiene. 27 is marked other than "natural", or items traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify ģ SpecifyWhite 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 Budget Clerk Federal Covernment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ben Watson Eula Sheffield 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a sortant; If item 27 is / Injury or other trau David C. Lawson/Son 10207 Haywood Drive, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 Removal from State Nov. 8, 2007 permit. Page Department of Important; If any Injury or once, Happy Valley Memorial Park 4 □ Donation 5 □ Other (Specify) Flizabethon, Tennessee 21. Signature Funeral Service License 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Cerl cru 0 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) onebrovence Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-tran and Due to (or as a consequence of) physician Physician/Medical as attending | IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No s been signed by the s 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an

Physician /Medical **Examiner**

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

cate has page 2 s funeral director.

The law requires that the death certificate be executed

P.O. Box 68760

Division or Vital Records,

or Attending Physician:

this

After

To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu

Completed by Be မ Certification:

Medical

autopsy performed? 2₽No 1□ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 \No

27. Manner of Death 1 Matural 2 Accident 3 ☐ Suicide

5 Pending investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury 28b. Time of (Month, Day Year)

2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

TAKOMA PARK, MD 20912

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 Homicide

1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature, and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

useuch War, M. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0063703 1600 CARROLL AUG

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31. Date filed (Month, Day, Year) NOV 06 2007



1 npatient

Registrar

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a To the Funeral C

29a. Certifier 1 🖪 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

20785



31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

Medical (



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 7 0 7 Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:15 P M 16, 2007 Calvin November Roger Mellem /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 11633 Asbury Circle Calvert Solomons If Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 485-20-4070 83 08-23-1924 **Director** Iowa Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10a, State 10b. County r 28a-f show notified at show Solomons MD Calvert 1 ☐ Yes 2 🔀 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Iral", or Items 23a or Examiner must be 20688 United States 11633 Asbury Circle Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours afterment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Itelury or other traumatic event, the Medical Examiner 1 XYes 2 □ No if Yes, Give WWII Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Architectural Firm Architect 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eddie G. Mellem Bessie Halvorson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy R. Mellem (Wife) 11633 Asbury Circle, Solomons, Maryland 20688 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of H Important: If ite any Injury or of 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 11/19/07 Alexandria, Virginia 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licenses 处 P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final veeks Physician Liver cancei disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after To the Funeral Discompletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 19, 2007 ss of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick MD 20678 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) _2007 Month MUZYK GEORGE October 30. 1820 P^{M} ALEXANDER 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 4,1943 9. Birthplace (State or Foreign Country) New York Months Days Hours Min. 1X M 2 □ F 214-42-2679 64 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a State 10h Counts 1 ☐ Yes 2 → No Maryland Montgomery Germantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19500 Crystal Rock Drive #22 20874 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alexander Frank Muzyk Evelyn Werner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Muzyk Disher- sister 15 Tierra Montanosa Rancho-Santa Margarita, CA 92688 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Arlington Natl. Cem. Nov.2,2007 Arlington, VA. 21. Signature of Funeral Service Lic 22. Name and Address of Facility DeVol Funeral Home Deer Park Drive - Gaithersburg, MD. 20877 Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure. pase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) APDIAC MINUTES Due to (or as a consequence of): ESPIRATO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MYOCARDIAL INFARCTION Due to (or as a consequence of): RENAL 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PANCYTOPENIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform

Physician

Physician

/Medical

Examiner

Funeral

Director

show

ral", or items 23a or 28a-f shov Examiner must be notified at

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other traumatic event, the Medical

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Important: If iter
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72 hours after

3altimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

Director

Funeral

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/Medical Examiner law requires that the death certificate be executed attending physician and for use as the burial-transi

signed by the at d be detached for

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To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu

funeral

Completed by

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Certification: To

Medical

Examiner Physician/Medical IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 2D No 1 Tyes

27. Manner of Death

Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

5 Pending investigation

6 Could not be determined

1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Injury 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 00064478 29d. Date signed (Month, Day, Year) 10-31-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ISEHATSION 31. Date filed (Month, Day, Year)

MEHARI Registrar's Signature

9901 MEDICAL CENTER DR. ROCK.

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

			For State	State	of Maryla		artment of		nd Mental	Hygie	ne		
			Registrar			Cei	rtificate of	Death	т	Reg.	No.2 1 1 7	37	360
	Physici	an	Decedent's Name (First, Middle	le, Last)					Mon		Day Year	3. Time	or Death
	/Medic		Grace S.	Murphy							4, 2007	8:50	P M
	Examin	ier	4a. Facility Name (If not institution Kingshire Manor		· ·	ı G	4b. City, Town, Rockvil		Death		4c. County of Deat		
u _e Ch	Funeral	165	5. Social Security Number	6. Sex		rs. last birthday)	If Under 1 Year	If Under 24		of Birth	9. Birt	hplace (State	or Foreign
	Director		577-54-6369	1 □ M 2 🖾 F	9	6 Yrs.	Months Days	Hours		th, Day, Ye	,1911 New	York	
7			Usual Residence of Decedent		100	City Taylor and a							
alvie	shov ad at	5	10a. State 10b. County Maryland Montg			City, Town or Lo aithers1						10d. Inside (s 2 No
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he filed within 72 hours after death with the Maryland	raľ, Exar	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, G Year or I			1⊡Yes 2X⊡No	Specify:			Specify: W	hite	
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Shoul	marl marl	F	19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailir	ng Address (Stree	↓			ty or Town, State, 2	ip Code)	
and 2	Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Robert Murphy	(Son)		1219	Main St	reet, G	Gaithers	burg,	MD 20878	3	
2 - S	of He f item r oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 Domewal from		. Place of Dispo	sition (Name of matory or other pla OPOLITAN	ace)	Date		. Location - City or	Town, State	
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a mit	eparti nport ny Inj nce.		21. Signature of Funeral Service	Licensee		I	2. Name and Addr	,			al Home	· · · · · · · · · · · · · · · · · · ·	
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The law requires that the death certificate be executed	ohysician and the burial-transit	Physician/Medical		d									
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e de	by the a	/sici	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Preg 9□Unki	jnant at time o nown	of death 5	Other (specify)			_	WOULD	Day	Teal
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	certificate ector, paç	ပို	25. Was case referred to medica	ı I				26 Place o	of Death (Check	performed Yes 2	No 1 ☐ Yes	2□ No	
Vslci	this certifical director.	To B	examiner? 1 ☐ Yes 2 2 No	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3□ DOA Of	hor:			e 6 K Other (Spec	Ass	isted
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To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: A completely filled in by the fi		00-0-0-0-	Dhustal T "	a best -f !	emanula de la dell	b = = = = = = = = = = = = = = = = = = =	tions determine		4 - 41 -	-/->		
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1	>		30. Name and address of person	who completed cau	ise of death (I	tem 23a) (Type,	Print)						
			Ravi Passi, M.D	. 15225 S	hady G	rove Ro	ad, Rock	ville,	Marylar	nd 208	50		
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State of Maryland	/ Department	of Health	and Menta	al Hygier
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			For State Registrar	State of Marylar		Certificate of L		_	eg. No. 🤈 🦳 🦳	7 27261
			1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	th CUU	3. Time of Death
	Physicia /Medic		Wallace E. Mille	r, Sr.				Nonth NWEND	EK 3 200	11/2/7 11
	Examin		4a. Facility Name (If not institution, given	ŕ			Location of Death		4c. County of D	
			Doctor's Communi		laat histh	Lanha	m If Under 24 Hrs.	8. Date of Birth		George's
	Funeral Director		5. Social Security Number 219-16-2521 Usual Residence of Decedent	Sex 7. Age (In yrs. 84	Yı	Months Days	Hours Min.	(Month, Day	, Year)	Birthplace (State or Foreign Country) attsville, MD
land	W t		10a. State 10b. County	10c. Ci	ty, Town o	or Location				10d. Inside City Limits
Mary	f sho	ţō	Maryland Prince	George's		Hyattsvil	1e			1 ☐ Yes 2x No
h the	r 28a notii	Directo	10e. Street and Number			10f. Zip Code		1	l0g. Citizen of What	Country?
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dea	ems er mu	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S.	 Was Decedent of H If Yes, specify Cuba 	ispanic Origin? (Span, Mexican, Puert	ecity Yes or No- Rican, etc.)	14. Race - A Black, W	American Indian, Vhite, etc.
Maryiand 21215-0036 Id 2 should be filed within 72 hours after death with the Maryland	ntal Hygiene. Ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 🔼 Yes 2 □ No If Yes, Give Year or Dates: WWI	_	1 □ Yes 2X No				White
5-0 72 h	'natu dical	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)	1 6	ecedent's Usual Occup Give kind of work done	during most of wor	king	16b. Kind of Busine	ess/Industry
iffi i	than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ife. DO NOT use retired ales Repres	,		Miller Ch	omical
Elled V	Hygie ther t		17. Father's Name (First, Middle, Las	")	5	ares Repres			Maiden Surname)	Chitcat
E 8	S = 20	To Be	James Wells Mill	•			Fran	cis Chap	man	
laryla 2 should	nd Menta marked imatic ev	F	19a. Informant's Name/Relationship		19b. I	Mailing Address (Street		<u>-</u>		te, Zip Code)
	Health a em 27 Is other trau		Lesley A. DeHone	y – Daughter	76	17 East San	ds Dr.,	Scottsda	le, AZ 8	35255
es ta	of Health and Ment f item 27 is marked r other traumatic e	İ	20a. Method of Disposition	20b.	Place of E	Disposition (Name of crematory or other place	ce)	Date	20c. Location - City	or Town, State
Pages	nent c		1 ☑ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec	fy) Geon	rge Wa	shington Ceme	etery 11/	7/07	Adelphi,	Maryland
Baltimore, permit. Pages 1 ar	Department of H Important: If itel any Injury or ott once.		21. Signature of Funeral Service Lice	nsee	10-0	22. Name and Addre				timore Ave.
n 8	اة يم تا ت		Pornest	Colvin MC	1678					11e, MD 20781
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	hplications that caused the dea one cause on each line.	th. Do no	t enter the mode of dyir	ng, such as cardiad	or respiratory an	rest,	Approximate Interval Between Onset and Death
	ysician	11	Immediate Cause (Final disease or condition resulting in death)	_a. Cardiopulm						
	Medical caminer			Due to (or as a conse Renal Fail):				
	No.	-e	Sequentially list conditions,	b. Due to (or as a conse):				
uted	d ansit	Examiner	Sequentially list conditions, it is a significant cause. Enter Underlying Cause (Disease or injury that initiated events	Diabetes M	e11i	tus				
0 ,	an an rial-tr		resulting in death) Last	Due to (or as a conse						
68760, tificate be executed	ig physician and as the burial-transit	edical		Coronary A	rter	y Disease				
ertific 6	ling p	900	IF FEMALE:	000 16 100 0140 000 04 010 000						
death ce	attending for use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of	al death	3 ☐ Ectopic pregnancy	/		23d. Date of Month	f delivery Day Year
i ş	by the a	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	deam	5 Other (specify)				
Records, P.O. The law requires that the	signed by be deta	/ Ph	Part II. Other significant conditions	contributing to death but not re	sulting in 1	the underlying cause giv	en in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
rds guires	n sigr ıld be	d by	Chronic Lymphocy	tic Leukemia				1 □ Y	′es 2 No 3	Probably 4XUnknown
S ve	s been sig	Completed						24a. Was a		re autopsy findings available
E	this certificate has al director, page 2	E						autop perfor	rmed? deat	r to completion of cause of th? Yes 2 ☐ No
Vital	rtifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o		
) V	his ce I direc	70	1 Yes 2 No	Hospital: 1 ☑ Inpatient 2] ER/Outp	oatient 3 DOA Oth	er: 4 Nursing H	ome 5 Resid	lence 6 Other (Specify)
	Vfter thunderal		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Ti	ury Wor	k?	28d. Describe h	now injury occurred	
SiO	er death. rector: / by the fu	cati	2 Accident investigation 3 Suicide 6 Could not		nome farr		Yes 2 □ No	28f Location /6	Stront and Number of	or Rural Route Number,
Division or	24 hours after death. Funeral Director: After tely filled in by the funer	Certification:	4 ☐ Homicide determined	building, etc. (Spec	ify)	ii, sileet, lactory, ollice		City or Tow	vn, State)	ir Hurai Houte Hurriber,
Spital	24 hours a Funeral etely filled			hysician: To the best of my kr						
Division or Vital Records, P.O. Box to the Hospital or Attending Physician: The law requires that the death cer	within 24 hours afte To the Funeral Di completely filled in	Medical	(Check only 2 Medical Exa	miner: On the basis of examir and manner stated.			•		·	
To th	within 2 To the complete	M	29b. Signature and title of certifier	P		29c. Licens	e number		29d. Date signed (M	fonth, Day, Year)
)			M. M.	J		102	5 977		11/5/	01
2/	20/41		30. Name and address of person who	completed cause of death (Ite	m 23a) (T	Type, Print) HANOU EIR P	AKKWAY	50178 /	A CREFINI	BELT MO 20170
Į.	Sta Regist		NOV 0 6 2007	completed cause of death (Ite	old	ر ^ر				5

State Registrar

DHMH 17 Rev 1/2001

1328

Southern Ave SE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD. 32. Registrat's Signature

Bosella

me

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1- For Amend PII & 25, perME, g876, 2/28/08 Tertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 4:11 PM OCTOBER 30 -MMANH 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DSPITAL TIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Funeral Days Hours Min. **X**XM 2□ F Yrs 219 58 8940 **Director** JULY 21, 1953 WASHINGTON, DC 54 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at XXYes 2 □ No Director MD PRINCE GEORGES CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 Is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be nother traumatic event, 5637 SOUTHERN AVENUE 20743 UNITED STATES Funeral . Was Decedent Ever in U.S. Armed Forces? 1 □ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. XXNever Married 2☐ Married 1 ☐ Yes XX No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10th College (1-4or 5+) MNPPC LABORER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 WILLIE MARKS MAGELENE FLOWLER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

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			For State Registrar	State of Marylar	nd / Depa	artmer		-	lygiene	007	373	65
	Physici		1. Decedent's Name (First, Middle, Last)	EDALE MO	ORE		,	2. Date of Month	Death Day	Year 200	3. Time of 21:00	
	/Medio Examir		4a. Facility Name (If not institution, give GARRETT COUNTY MO	street and number)		01	Town, or Location of	Death	4c.	County of Dea	7 604.	
100	Funeral Director		5. Social Security Number 6. Security 1 Control 1 Contro	7. Age (In yrs	. last birthday) Yrs.	If Unde Months	T 1 Year If Under 2 Days Hours	Min. (Month,	Birth Day, Year) 6, 19	9. Bii C 24 Oa	rthplace (State of ountry) kland, N	r Foreign MD
	Maryland	tor	10a. State 10b. County MD Garrett		ity, Town or Lo	ocation					10d. Inside Cit 1	
	th with the 23a or 28a	ai Direc	10e. Street and Number 706 E. Alder Street	et			Code 550			ted St		
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "naturel", or items 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at or other traumatic event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes ※ ※ No If Yes, Give Year or Dates:			dent of Hispanic Orig city Cuban, Mexican, 2 X No Specify:	in? (Specify Yes or Puerto Rican, etc.)	:	4. Race - Am Black, Wh Specify: W		
21215-0036	vithin 72 ho ne. hen "natur n Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	1		al Occupation ork done during most ise retired)	of working		nd of Business		
	ould be filed w Mental Hygiel arked other ti atic event, th	Be	17. Father's Name (First, Middle, Last) Gilbert Carroll We	eimer	ass	embly	į	's Name (First, Mide	dle, Maiden		artin	
Maryland	d 2 should th and Men 27 is marke r traumatic	To.	19a. Informant's Name/Relationship (Ty	pe, Print)			s (Street and Number	or Rural Route Nui	nber, City or	Town, State,	Zip Code)	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra ance.		20a. Method of Disposition 1 \(\begin{align*} \text{Burial} & 2 \text{Cremation} & 3 \text{F} \\ 4 \text{Donation} & 5 \text{Other} \((Specify) \)	20b.	Place of Dispo cemetery, cre-	osition (Na matory or	me of	Date 11/11/200	7 20c. Lo	cation - City o	r Town, State	
Balti	permit. Departm Importe any inju		21. Signature of Juneral Service Licens			2. Name a Davi	nd Address of Facility d A. Burdo . Second	, ock Funer:	al Hom	e. P.A		
	Physician /Medical Examiner		23a. Part. Enter the disease, or complete speck, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a. A curt Co Due to (or as a conse	quence of):	Puir	ONARY A	RREST		L Honors	Approximate Interval Betwoest and E	ween Death
760,	te be executed ysician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse CORDANT Due to (or as a conse CHRONIC	quence of): Ap nmy quence of):	9.	sons6					
O. Box 687	The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 仅 No 9 □ Unknown	3c. If yes, outcome of pregr 1	nancy tal death 3	□Ectopic p	regnancy			3d. Date of de	•	Year
ords, P.O.	equires that the signed by ould be detacted	ed by Ph	Part II. Other significent conditions con	MARVAY FA	11425	, ,	cause given in Part I.		id tobacco u		to the cause of d	
al Records,	: The law ri cate has be page 2 shi	Complet	1 CUTT ROW	n Facund	F			24a. W ai pe 1 🗆 Ye	itopsy erformed?	prior to death?	autopsy findings a completion of ca es 2 No	available ause of
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Divisi	s after deal	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, facto	y, office		n (Street and Town, State,		Rural Route Num	ber,
	the Hospit nin 24 hour the Funera npletely fille	Medical ((Check only 2 Medical Exemi	sician: To the best of my kn ner: On the basis of examin and manner stated.		rvestigation	n, in my opinion, deat		ne, date and	place, and du	ie to the cause(s	;)
)	To To Con	2	29b. Signature and title of certifier	MJ.			D 51 564				oth, Dey, Year)	/9/07
		3	30. Name and address of person o or A A . Z/ 31. Date filed (Month, Day, Year)	AKALUTNY	MD	, Print) 25	D51564	ST Sucr	e 2 C	PAKLHE	MD 2	1550
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			1 - For State Registrar	State of Ma	arylan	•	nt of Health and ate of Death	Mental Hy	giene 007	37366
- J.			Decedent's Name (First, Middle, L.)	ast)				2. Date of D		3. Time of Death
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	LAGITION	101	2	res Comm	an to	Hor tol 1	heverly		Prince	e George's
	Funeral		5. Social Security Number 2.	Sex 7. Ag	e (In yrs.	last birthday) If Und	er 1 Year If Under 24 Hrs		rth 9. Bi	rthplace (State or Foreign
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rylar	how	_	10a. State 10b. County	0 1		y, Town or Location	11			10d. Inside City Limits
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death with the Maryland	teme 23s or 28a-f ehow ser must be notified at	Funeral Director	4/31 New B	ent Dri			20772		United	States
e de	te m	nne	11. Marital Status	12. Was Decedent Armed Forces?		S. 13. Was De	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	Specify Yes or N to Rican, etc.)	0- 14. Race - Am Black, Wh	
36 s afte	o.	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 💢 l	No	1 ☐ Yes	2 No Specify:		Specify: /	Black
1215-0036 within 72 hours after	lural al Ex	d b		Year or Dates:		16a Decedentia II	aval Casumatian		16h Kind of Business	// SCII
15 n	" na	Completed	15. Decedent's I (Specify only highest g	rade completed)		16a. Decedent's U (Give kind of life. DO NOT	work done during most of wo use retired)	orking	16b. Kind of Busines:	sylindustry
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and Id be file	c eve	o Be	Lewis Par	rker			Mario	le Pou	rech	
Mary d 2 shoul	mari mati	은	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing Addre	ss (Street and Number or R			Zip Code)
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ව් දූ	Hea tem othe		20a. Method of Disposition	7_1167 021,	20b-P	lace of Disposition (A	lame of	Date	20c. Location - City o	r Town, State
2008	ant of		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		Ma	Place of Disposition (Nemetery, orematory)	prother place) Nov	21	Emporia,	Virginia
Baltimore, permit. Pages 1 av	artme ortan injur		21. Signature of Funeral Service Lice		4	CHUICH C				
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2	20 6		23a. Part 1. Enter the disease, or	MUIZA	the death	Do not enter the m	ode of dving, such as cardia	c or espiratory	porta, va,	Approximate
10.00			shock, or heart failure. List ont	y one cause on each lir	10.					Interval Between Onset and Death
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760 te be e	ysician ie buria	cai		d.						
. BOX 68 death certifica	andin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	elivery
deat.	d for	Icia	in the past 12 months?	1□Live birth 4□Pregnant at					Month	Day Year
) §	ed by the attending ph detached for use as th	Physician/Med	9 Unknown	9□ Unknown						
Hecords, P.O.	signed b	ру Р	Part II. Other significant conditions	contributing to death be	ut not resu	ulting in the underlying	cause given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
VITAI KECOLUS, ician: The law requires t	been sig should b	ed h	Encephalop	a Dy	and	0610)		1 🗆	Yes 2 No 3 F	Probably 4 Unknown
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O9	th. : After this certifica funeral director, I	0 8	examiner? 1 Yes 2 No	Hospital:	nt 2 🗆	ER/Outpatient 3 1	Othon		idence 6 ☐Other (Sp	ecifu)
	eral	H	27. Manner of Death	28a. Date of Injur (Month, Day	y	28b. Time of	28c. Injury at Work?	T	how injury occurred	
/ISION Attending	death. ctor: Aft y the fun	atio	1		(Fear)	Injury M	1 ☐ Yes 2 ☐ No			
UIVISION or Attending	after death Director: I in by the	ertification:	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of Inju	iry - At ho	me, farm, street, fact	ory, office		(Street and Number or F wn, State)	Rural Route Number,
ב ב	s after al Dire ed in by	Cer	· C Trombad	building, etc	. (opocny	,		Only or re	wii, Gialey	
Hospi	24 hours after of Euneral Directed Fundral Directed Filled in by		(Uneck only 2 Medical Exa	hysician: To the best of	of my kno examinat	wledge, death occurre	od at the time, date and place on, in my opinion, death occ	e, and due to the urred at the time	cause(s) and manner a	as stated.
the	within 2 To the Complet	Medical	one) 29b. Signature and title of certifier	and manner sta	ted.		9c. License number Don 18 Stry Rd Hy		29d Date signed (Mos	nth Day Year
2	3 H 8	_	200. Organizate and title of certifier	. 0.11-	0 1		1 / R	53	1 and I amor	7
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IR	4		30. Name and address of person who	completed cause of de	eath (Item	23a) (Type, Print)	L. D. M.	atta.	He MINO	27 Ri
177) [MUT. UV	ORE MIN 4	403	QUEENS	Dung Ka 174	411201	- July 2	,01
1	Sta	٠	31. Date filed (Month, Day, Year)	37 MEANTH CTTC						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1:10 PM 1 6.2007 4c. County of Death ovember Alphrosine Margareta Metts /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cumberland Allegany

9. Birthplace (Sta Lions Center If Under 1 Year Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) (State or Foreign Funeral Min Months Days Hours 1 M 2 Director 130-56-8450 September 06, 1957 Germany Usual Residence of Decedent the Maryland 10a State 10c City Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 Yes 2 No Director Maryland Allegany Midland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ns 23a or 2 must be n ural", or items 23a o Examiner must be by Funeral 14917 Railroad Street 21542 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced U.S.A Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook Pizzeria 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Mental 17 is marked of traumatic ever permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev 2 Ludwig Doell Margareta Zweyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael Joseph Metts - Husband 14917 Railroad Street, Midland, Maryland, 21542 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1. Burial 2 □ Cremation 3 □ Removal from State November 4 ☐ Donation 5 ☐ Other (Specify) Laurel Hill Cemetery 09, 2007 Moscow Mills, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 Fast Main Street, Lonaconing, Maryland, 21539 23a. Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Small 2 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician s the burial Division or Vital Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown certificate has been si rector, page 2 should 24a. Was an autopsy performed?

1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending s after decrai Director: After investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NOV 06, 2007

Registrar

State

Kel. Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

32 Registrar's Signature

31. Date filed (Month, Day, Year)

- 9

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		naryiano		tificate of			Reg. N	0007	37368
П	Physici	an	Decedent's Name (First, Midd						2. Date of De Month		year 2007	3. Time of Death
*	/Medic		Angelia Michel				45 Oit T	-1				8:30 A ^M
	Examin	er	4a. Facility Name (If not institution Kline Hospice H		r)		Mt. Airy	r Location of Death	1		c. County of Deat Fredericl	
	Funeral		5. Social Security Number		Age (In yrs. la	as <i>t birthd</i> ay)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		I o Dia	nplace (State or Foreign
	Director		241-33-1063 Usual Residence of Decedent	1□ M 2 X 1F	34	Yrs.	Months Days	Hours Min.	Nov 9,	y, Yea 19	72 Mar	yland
	aryland show dat	_	10a. State 10b. Count			, Town or Lo	cation					10d. Inside City Limits 1 X Yes 2 No
	Ba-f s	ecto	MD Freder	rick	Fred	lerick						
	with the	ä	10e. Street and Number				10f. Zip Code			-	Citizen of What Co	untry?
	sath is 23;	eral	2510 Emerson Di	rive 12. Was Deceden	nt Ever in II S	2 12 1	21702	lienanie Origin? (S	pocify Voc or No	USA	A. 14. Race - Ame	rican Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 □ Divorce	Armed Forces arried 1 Tes 2 Tes Give	X No 3.	i	Nas Decedent of H f Yes, specify Cuba I ☐ Yes 2☐XNo		o Rican, etc.)	-	Black, White	
0-10	72 hor	ted		ent's Education nest grade completed)	- 1	16a. Deced	lent's Usual Occup	ation	kina	16b.	Kind of Business/	ndustry
218	ithin 7 le. lan "r Med	nple	Elementary/Secondary (0-12)				kind of work done OO NOT use retired		Kilig			
21	ed wi lygier ner th	S	12	()		Accou	nt Manage		(F) . A () 4 H		surance (Company
and	be fi	Be	17. Father's Name (First, Middle Cornelius D. Mc					18. Mother's Nan Mattie B	, ,		,	
ž	hould d Me mark matic	ပ္	19a. Informant's Name/Relation			19b Mailir	g Address (Street					in Code)
Ma,	and 2 stalth an 27 is i		Christine M. Te			1	Emerson					ip code)
Baltimore, Maryland 21215-0036	Pages 1 and of He int: If item		20a. Method of Disposition 1 Burial 2 TCremation 4 Donation 5 Other (n 3 □Removal from Stat (Specify)	e ce	emetery, crer	sition (Name of natory or other plac ke Cremat	· · · · · ·	6, 200		Location - City or ${ t eltsvill}$	·
Balti	permit. Departn Importa any Inju		21. Signature of Funeral Gervice	e Licensee		G(Name and Addre	ss of Facility Cremati	on Serv	ice	P.O. Bo	ox 784
			23a. Part1. Enter the dispase, of shock, or heart failure. Lis	or complications that caus	MO12 ed the death.	. Do not ent	ever1y L. er the mode of dvir	Heckrot	te, P.A.	C	larksvil	Approximate
	Dhysisian		shock, or heart failure. List Immediate Cause (Final					9,				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Cirrho	sis, C as a consequ		enic					7 years
	Examiner	er	Sequentially list conditions,	b. Pancyt								months
	uted ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Renal	Failur	• 👝						1 year
Ć.	execting and ital-tra	Еха	resulting in death) Last		s a conseque							ı year
68760,	rificate be executed Ig physician and as the burial-transit	edical		d Liver	<u>Failur</u>	e						1 year
	ertific ling p		IF FEMALE:									
.O. Box	The law requires that the death cer to has been signed by the attendir bage 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 【 Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fetal at time of de	death 3]Ectopic pregnancy]Other <i>(specify)</i>	/		50	23d. Date of del Month	very Day Year
<u>а</u>	es that gned by se deta	by Ph	Part II. Other significant condit	tions contributing to death	but not resul	Iting in the u	nderlying cause giv	en in Part I.				the cause of death?
ord	requir	ted							10	Yes	2 No 3 Pr	obably 4 Nunknown
Vital Records,	10	Completed							24a. Was autoj perfo 1∐ Yes		prior to o	topsy findings available completion of cause of 2□ No
Vita V	Physician: Th r this certificate ral director, pag	Be (25. Was case referred to medic examiner?				Low		ath (Check only o	ne)		
or	Phys this al dir	P	1 ☐ Yes 2 🛣 No 27. Manner of Death	Hospital: 1 ☐ Inpa 28a. Date of In		ER/Outpatien		4 🗆 Nursing F	fome 5 Resi			cify) hospice
uo	ding I	ion	1 Natural 5 ☐ Pendi	(Month F		Injury	Wor	k? Yes 2∐No	zou. Describe	ilow iiij	ary occurred	
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could	d not be 28e. Place of it	njury - At hor etc. <i>(Specify)</i>	me, farm, str	eet, factory, office		28f. Location (City or To			ural Route Number,
_	To the Hospital or within 24 hours after To the Funeral Dir completely filled in		(Check only 2 Medica	ring Physician: To the bes al Examiner: On the basis	st of my know	vledge, deatl	n occurred at the tir	me, date and place	e, and due to the	cause	(s) and manner as	stated.
	To the h within 24 To the f complete	Medical	one) 29b. Signature and title of certifi	and manner			29c. Licens				Date signed (Mont	
	F ≶ F ŏ		•	79/H	24		05	4639		/	15/0	
C	100		30. Name and address of person	on who completed cause of	death (Item	23a) (Type,	Print)			-		1
٧) a3-		Emily Hsu, M.D.	. 7190 Crest	wood B	Blvd.		, MD 217	03			
	Sta Registr		31. Date filed (Month, Day, Year NOV 0	7 2007	strar's Signati	K. A	berli					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:00 Am Anna October ,2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Prince George 5 9. Birthplace (State or Foreign Country) 1909 Virginia Laure reater Laure Wursing and Rehab. Ctv. ial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8-28-9211 1 M 2 XF 97 Yrs. Months Deys If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, 5. Social Security Number 228 - 28 - 9211 Funeral Director Usual Residence of Decedent death with the Maryland 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Examiner must be putilled at once. 10c. City, Town or Location Chesterfield Chesterfiela 1月Yes 2□No Virginia Directo 10e. Street end Number 10g. Citizen of What Country? 23832 Summerstrace Terrace United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Housewite 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Josephine ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6900 Summerstrace Terr, Chesterfield, UA 23832 Woodley (Grandson Nov. 3 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Tyler Family Cemetery Jarratt. 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pear 5 on Funeral Service Ser Emporia, Va. 23847 **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 □ Probably 4 ☑ Unknown ģ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed within 24 hours after death. To the Funeral Director: After this certificate has 1 TYes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 ☐ Yes the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

o completed cause of death (Item 23a) (Type, Print) 3635

egistrar's Signature

29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

Name and address of person

NOV 0 6 2007

31. Date filed (Month, Day, Year,

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

37370 3. Time of Death

)	Physici /Medic Examin	a
	Funeral Director	

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 112 CHOPTANK AVE. **EASTON** If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Days 1 XM 2 ☐ F Months 77 Yrs. 214-28-1803 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County ms 23a or 28a-f show must be notified at Director TALBOT EASTON MD 10e. Street and Number 10f. Zip Code 112 CHOPTANK AVE. 21601 Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes X No Specify: 2 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BRICKLAYER 12 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill. Health and Mental H tem 27 is marked oth other traumatic even Be WILLARD M. NORTH, SR. WILSIE SHORTER 19a. Informant's Name/Relationship (Type. Print) RENEE NORTH/DAUGHTER other 1 permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ■ Burial 2 □ Cremation 3 □ Removal from State WOODLAWN MEMORIAL PARK 10/30/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee JOHN R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CACINOMA **Physician** 02 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signe should be d ð Completed 24a. Was an cate has page 2 s perform certificate 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, f Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Yes 2 | 1√10 P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? Certification: 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier and manner stated. 29b. Signature and title of certifie m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUDWIG J. EGLSEDER III, M.D. 503 CYNWOOD DR., EASTON, MD 21601 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 2 9 2007 Registrar

25 2007 WILLARD M. NORTH, JR. OCTOBER 6:35PM ^M 4c. County of Death TALBOT 9. Birthplace (State or Foreign SEPT 11 1930 MARYLAND 10d. Inside City Limits XXYes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian Black, White, etc Specify: WHITE 16b. Kind of Business/Industry CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 DIAMOND ST., EASTON, MD 21601 20c. Location - City or Town, State EASTON, MARYLAND 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST., EASTON, MD 21601 Approximate Interval Between Onset and Death 401 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State Registrar AMEND#8perFH11/6/07, BMW, MoCoCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Vear Robert Arthur Niemann 2007 /Medical 10:40 November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville 327 King Farm Blvd. #106 Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year)1929 Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1⊠M 2□F Director 218-24-4857 78 Sep 13, -2007 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 TXTNo Director MD Rockville Montgomery 10e, Street and Number 10f, Zip Code 10g, Citizen of What Country? 327 King Farm Blvd., #106 20850 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than the M Elementary/Secondary (0-12) College (1-4or 5+) Information Services Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Niemann Elizabeth Mary Lord ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas A. Niemann (Son) 109 Norwich Lane Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Parklawn Mem Park 2007 Rockville, MD 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Months a Metastatic Transitional Cell Cancer of Ureter disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner if any, leading to inmedit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) anding physician ause as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Be Certification: To

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica after death.

Director: After this certification by the funeral director.

1 Yes 2 No 9 □ Unknown	9 Unknown			
Part II. Other significant conditions o	ontributing to death but not resulting in the underlying cause given i	li)		se contribute to the cause of death? No 3 Probably 4 Unknown
			. Was an autopsy performed? Yes 2√□ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	26	6. Place of Death (Check	only one)	
1 ☐ Yes 2 ☐XNo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:	4 ☐ Nursing Home 5 🔀	Residence 6	□Other (Specify)
27. Manner of Death 1 ⊠ Natural 5 ☐ Pending 2 ☐ Accident investigation			cribe how injury	occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Locat City (ition (Street and or Town, State)	d Number or Rural Route Number,
29a. Certifier 1 CertifyIng Ph (Check only one) 2 Medical Exan	ysiclan: To the best of my knowledge, death occurred at the time, niner: On the basis of examination and/or investigation, in my opini and manner stated.	date and place, and due to on, death occurred at the	to the cause(s) a time, date and	and manner as stated. place, and due to the cause(s)

29c. License number

D0061083

29d. Date signed (Month, Day, Year)

12007

D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Thambi MD. 9707 Medical Center Drive #300 Rockville, MD 20850

State Registrar

Medical

29b. Signature a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician Gladys L. Nicholls)ctober 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Doctor's Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 1 x F Director 578-12-6692 86 9/29/1921 West Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show "natural", or Items 23a or 28a-1 snov edical Examiner must be notified at 1√Yes 2 No Maryland Prince George's Director Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9104 3rd Street 20706 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2K No Specify. Specify: ð 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Diamond Cab Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill treent of Health and Mental H tant: If item 27 is marked ott David T. Dunn Mary C. Stone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trat once. 9104 3rd Street, Lanham, MD Merrijeanne Mitchell/Niece 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 11/2/2007 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityFort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of) Examiner IFNGRENE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed MELLITUS DIABETES and burial-tra Due to (or as a consequence of) Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 N Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? res 2 No certificate | 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Depatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 4 hours after death. 1 Natural 5 Pending investigation the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

the the

> 31. Date filed (Month, Day, Year) State 2007 NOV 0 6 Registrar

29b. Signature and title of certifier



and manner stated.

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ပ

29c. License number

00050951

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1- State Amend #8, 11-13-07, per Full Rigidal Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Donald David Nusbaum November 4 2007 9:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City 9109 Winding Way Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 3 = 8 - 17 9. Birthplace (State or Foreign March 9, 1917 Ohio 7. Age (In vrs. last birthday, **Funeral** Days Hours Min. 1 XM 2 □ F Director 320 30 3225 90 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show Iry or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9109 Winding Way 21043 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1938–58 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Chief Gunners Mate US Navv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Nusbaum Lena Roth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Nusbaum/Son 6287 Gentle Lane Alexandria, VA 22310 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 12-18-2007 Arlington, VA Arlington National 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complication. hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Obstructive Polmonary Disease > Syears Immediate Cause (Final disease or condition resulting in death) Chronic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 🏋 No 24a. Was an this certificate has ral director, page 2 autopsy performed? 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, it Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 032924 11-6-07 of death (Item 23a) (Type, Print) 30. Name and address of person who completed cau BALTIMORE S 900 20 gistrar's Signature 31. Date filed (Mont State 2007 Enless. 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM/Ha. 25 periVR. #9.10a periff 873 11/21/07 VS

State of Maryland Pepariment of Health and Mental Hygiene Reg. No 2007 37375 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician November 7. 2007 Edward William Ott Sr. 1:02 Pm /Medical 4a. Facility Name (If not institution, give street and number)
Frederick Memberial Hospital Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial 5. Social Security Number (In yrs. last birthday) 59 Yrs. If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) August 5, 1948 9. Birthplace (State or Foreign Country Virginia **Funeral** 212-50-9407 1 ☑ M 2 ☐ F Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Frederick Adamstown Director 1 ☐ Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or ? 5144 Doubs Road 21710 United States 7 is marked other than "natural", or items 23a (traumatic event, the Medical Examiner must b death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc. within 72 hours after 1 XYes 2 No If Yes, Give Vietnam Year or Date Vietnam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Industrial d 2 should be filed w h and Mental Hygier ? is marked other tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any Injury or other traumatic ev Wilbert Ott Evelyn Davis ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Ott / Wife 5114 Doubs Road, Adamstown, Maryland 21710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 November 1 ☐ Burial 2 【Gremation 3 ☐ Removal from State Smithsburg Crematory 10, 2007 Smithsburg, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses eeney & Basford P.A. Funeral Home 06 East Church Street, Frederick, M01433 MD 21701 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (a consequence of) Examiner organization is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (d) certificate be executed and buriat-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) Day Year 4□Pregnant at time of death Records, P.O. 9 Unknown 9 Unknown þ signed L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 Tyes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has e 2 s autopsy page performe certificate Division or Vital 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo P 2 ER/Outpatient 3 □ DOA 1 ☐ Inpatient this funeral c 27. Manner of Death e Hospital or Attending P 24 hours after death. e Funeral Director; After the felely filled in by the funera 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) ی 24 hours. the Funeral Direco 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) VE FREDERICK MD 21702 15 32. Registrar's Signature State Registrar

/Medic Examin	ć
Funeral	
Director	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Itema 23a or 28a-f ehow any Injury or other traumatic event, the Mudical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Pnysician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1 - State Of Will Registrar	Cei	rtificate of		wientai i i	Reg. No.	007	37376			
ian	1. Decedent's Name (First, Middle, Last) Steven Douglas Rogers Olive	0 h			2. Date of D	Day	Year	3. Time of Death			
ical ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Dea	th IVEVENT		ounty of Death	1159A			
TIC!	420 Quaker Bottom Road		Havre d	e Grace			ford				
	216-88-9146 1X № 2□F	je (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ay, Year)	Cou	place (State or Foreig ntry) Lyland			
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation					10d. Inside City Limits			
ig	Maryland Harford	Havre de	Grace					1 ☐ Yes 2 X No			
Dire	10e. Street and Number		10f. Zip Code			_	n of What Cou	ntry?			
era	420 Quaker Bottom Road 11. Marital Status 12. Was Decedent	Everin II S 13	21078	dispania Origin? (Specify Vos or N	U.S.A	. Race - Ameri	oan Indian			
by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Yes 2 1 1 Yes, Give 3 Widowed 4 Divorced Year or Dates:	No	Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 No	Specify:	rto Rican, etc.)		Black, White,	etc.			
Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or state)	5+)	dent's Usual Occup kind of work done DO NOT use retired		orking		of Business/In				
Sol	17. Father's Name (First, Middle, Last)	Keal	Estate i		on a /Firmt & Sindsline		Estate	<u> </u>			
To Be	Charles Vallace Rogers				ime (First, Middle Campbell						
F	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street		_			code)			
1	Nancy Campbell Rogers (Moth		Quaker B			e de	Grace,	ND 21078			
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disponsion R.A. Fevr			Date 15/2007		ation - City or To				
	21. Signature of Funeral Service Dicerces		2. Name and Addre					ineral flom			
	23a. Part1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine.										
	resulting in death)	SPHYXIAT	TON					Onset and Death			
ı	Due to (or as	a consequence of):	_								
Je.	Sequentially list conditions, if any, leading to immediate cause. Eine Underlying Cause (Disease or injury	a consequence of):	3								
Examiner	that initiated events										
Medical Ex	d.	a consequence of):									
	IF FEMALE:						-				
Completed by Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	/		230	d. Date of delive Month	ery Day Year			
y Pr	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?			
ted t	None				1 🗆	Yes 2 💢	No 3 ☐ Prot	bably 4 Unknown			
omple						psy ormed?	prior to co death?	opsy findings available impletion of cause of			
Be C	25. Was case referred to medical			26. Place of De	1 ☐ Yes	2 No	1 ☐ Yes	2 X No			
၉	examiner? 1 XYes 2 No Hospital: 1 Inpatie			4 🔲 Nursing i			Other (Specif	ý)			
ilon:	27. Manner of Death 1 Natural 5 Pending (Month, Da		Wor	ry at rk? Yes 2 X No	28d. Describe						
flcat	2 Accident investigation November 3 Suicide 6 Could not be determined 28e. Pface of Inj	un - At home, farm, str	M	163 2 (18140			LICIEA Number or Rura	al Route Number,			
Certi	4 ☐ Homicide determined building, et	c. (Specily)	ME		City or To	wn, State) ENC					
Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physicien: To the best 2 Medicel Examiner: On the basis or and manner sta	of my knowledge, death f examination and/or in	h occurred at the tir	ne, date and place	e, and due to the urred at the time,	cause(s) ar date and pl	nd manner as s lace, and due to	tated. the cause(s)			
M	29b. Signature and title of certifier		29c. Licens				signed (Month,				
	Benard John, as Dr	ME	1000	4206		Noven	nla 14	- 2007			
	30. Name and address of person who completed cause of display. BERNARD YUKWA MI, DA	eath (Item 23a) (Type, VE 1614 (Print) PHYKCHV	ille Rd	BEL AI	R Mo	12101	5			
ate rar	31. Date filed (Month, Day, Year) 32. Registr	ar's Signature	AF -				-				

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene, 37377 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 26, 2007 11:33A. Helen C. O'Connell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3118 Gracefield Road, CC101 Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth NOV.11,1916 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 21 F 90 085-03-7709 Yrs. Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2X No Silver Spring Maryland Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 United States 3118 Gracefield Road, CC101 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. Item 27 is marked other than other treumatic event, the Me Personnel Administrator State Department 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill thent of Health and Mental Hitem 27 is marked of Be John O'Connell Helen Lane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3800 Waldo Avenue, #12E Bronx, New York 10463 Sheila A. Brosnan -cousin 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State ō permit. Page Department of Importent: if any injury or once. Gate of Heaven Cemetery 11/8/2007 Hawthorne, New York 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bonald V. Borgwardt Funeral Home, PA Rosald W.Bon 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure months Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension vears if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month for in the past 12 gronths? 1 ☐ Yes 2 ☐ No Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 90 Pulmonary Embolism 1 Tes 2 No 3 Probably 4 Unknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? 1 Yes 2 NO 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred After t or Attending 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospitel 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) npletely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and itle of certified October 29, 2007 D34590 Nes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy Fried, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene U

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2007 1:10PM PEGGY Y. PARKER 14. November /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Darlington 3330 Hughes Road 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 9/7/1942 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 3(XF Yrs. 65 Director 232-68-8071 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Directo Harford Darlington MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21034 USA 3330 Hughes Road death Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. Civil Service Postal Worker 12 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy important: if I tem 27 is marked othe sry injury or other traumatic event, since 17. Father's Name (First, Middle, Last) Be Agnes Moore Harvey Yeager 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George W. Parker/Husband 3330 Hughes Road, Darlington, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/17/2007 Darlington, MD 4 ☐ Donation 5 ☐ Other (Specify) Darlington Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA CO Part 1. Eviter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Unmediate Cause (Final disease or condition resulting in death) 3415 Metastatic Breast Cancer **Physician** /Medical Due to (or as a consequence of) Chronic obstructive Examiner Pulmorony Dislove Sequentiafly fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine 109/1 Hypo throng or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of Box 68760, physicien Physician/Medical use as the fF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of defivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by ate has been signi pege 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate has 21XNo 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Leath 1 Natural 2 Accident 28b. Time of 28c. friury at Work? After t Certification: 5 Pending after death.

Director: Aft 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a To the Funeral L Cartifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investmation in my price. Hospital 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier John J. Smeldre, 52 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suzzo Bel Air Ma Old Emoster Stephen G. Smaldoreso 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 11/40 Registrar

			1 - For State Registrar	State of	Marylan		artment of H		nd Mental	Hygier Reg. I	2007	37379
			Decedent's Name (First, Middle, Last))					2. Date of		Day Year	3. Time of Death
	Physici /Medic		Reita Todd	Powle	1/2					10/18	8/2007	2:50 PM
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			2213 South Bay Dr. 5 Social Security Number 6. Se		Age (In yrs. I	last hirthday)	'Todo If Under 1 Year	ville	Hrs. 8 Date of	of Birth		place (State or Foreign
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lan) 2 sho	and is me		19a. Informant's Name/Relationship (7)			1	•				ty or Town, State, Z	ip Code)
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Baltimore, Maryland permit. Pages 1 and 2 should be file	Department of Health and Mental Hygiene. Important: if itsm 27s or 28s-f show important: if itsm 27 is marked other than "natural", or itsms 23s or 28s-f show any njury or other treumatic sysnt, its Medical Examiner must be notified at ance.		4 Donation 5 Other (Specify) 21/ Signature of Funeral/Service Licens	-	DOL	T	Name and Addre					D
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Hosp	Fune Fune stely f	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	iner: On the bas and manne	is of examina	tion and/or in	n occurred at the til ivestigation, in my d	ppinion, death	occurred at the	time, date	e(s) and manner as and place, and due	to the cause(s)
To the Hospital	within 24 hours a To the Funeral C completely filled	Med	29b. Signature and title of certifier	1-	- 5)	29c. Licens	e number		29d.	Date signed (Month	n, Day, Year)
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	አ		30. Name and address of person who d	ompleted cause	of death (Item	п 23а) (Туре,	Print) P.O.	PIXOC	9 205			
خص	2		Vincent Lobo	D.C.	giotzario Cinc	ature *	Har	ringt	GIDE	199	23	
	Sta Regist		31. Date filed (Month, Day, Year) NOV 2 1 20		gistrar's Signa	Null O	residence of the second					

To the within 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie November 13, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD. 31. Date filed (Moeth, Day Year) 2007 32. Registrar's Signature State Registra DEME DHIVIN 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 7:00PM [™] JESSIE T. RINTLEMAN OCTOBER 20 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8099 RUBY HARRISON DRIVE BOZMAN TALBOT If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 ី F Months Hours 92 APR. 5,1915 ILLINOIS 579-09-7783 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director TALBOT BOZMAN 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 8099 RUBY HARRISON DR. 21612 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. other than "natural", or Iten /ent, the Medical Exaπiner 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE ģ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry DEFENSE Elementary/Secondary (0-12) College (1-4or 5+) 12 CONTRACTOR EXECUTIVE SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GEORGE E. THORNTON FREDA HANKE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 00 Health a GEORGE IRELAND/NEPHEW 8099 RUBY HARRISON DR., BOZMAN, MD 21612 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR. 10/23/2007 STEVENSVILLE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens PACTOR OF THE PACTOR OF THE PACTOR OF THE PACTOR OF THE PACTOR OF THE PACTOR OF THE PACTOR OF THE PACTOR OF THE PACTOR OF THE PACTOR OF THE PACTOR OF THE PACTOR OF THE PACTOR OF THE PACTOR OF THE PACTOR OF THE PACTOR OF T 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ANITION disease or condition resulting in death) /Medical demention process Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Day in the past 12 pronths? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has le 2 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No 1 ☐ Yes 1 Inpatient 3□ DOA 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) ဥ 2 ☐ ER/Outpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Negatifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0-22-0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT B. SANCHEZ M.D. 508 IDLEWILD AVE., EASTON, MD 21601 32. Registrar's Signatu 31. Date filed (Month, Day, Year)
OCT 2 3 2007 State Registrar

07-08561 Haim Reizes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aim Reizes	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death 2007 3738
Physician	Registrar Reg. No.
Aedical Examine	Month Day Year
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	612 Kenbrook Drive Silver Spring Montgomery
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Israel
Director	394-64-6475 1XM 2 F 77 Yrs. Months Days Hours Min. Sept. 14, 1930 Country Jerusaler
	Usual Residence of Decedent
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alti mit. partm ports ury o	21. Signature of Funeral Service Licencee 22. Name and Address of Facility - Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852
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Physician	23a. Part I. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and
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tal Records, cian: The law requires certificate has been sign ector, page 2 should be	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
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Division of Vital Records, tal or Attending Physician: The law requin ra rafter death. al Director: After this certificate has been s led in by the funeral director, page 2 should build the funeral director.	27. Manner of Death 28a. Date of Injury 5 1 Natural 5 Pending FOUND: 28b. Time of Injury 28c. Injury at Work? FOUND: 28c. Injury at Work? 1 Yes 2 No
ttend death ctor: y the i	Natural 5 Pending PoUND: 1700 hrs 1 Yes 2 No No Nov 3, 2007 1700 hrs
Division o spital or Attending tours after death. neral Director: Aft filled in by the fune	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
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Division of Vital Records, P.O. Box 68761 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Directors. After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the beginning Confident Confident or De Computed by Diversizion Market and Confident or De Computed or Deversizion Market and Confident or De Computed or Deversizion Market and Deve	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the Ite within 24 To the Facompleted	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
0	Signature and title of certifier O.C.M.E. November 4, 2007
~ ~	Caron Mucha
	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Stat	31. Date filed (Moth Tray Refs. 2007 32 Registrar's Signature
Registra	LOUI DIGGINA AND CONTRACTOR OF

07-08499 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Linda Rieg State of Maryland / Department of Health and Mental Hygiene 2007 37384 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 1, 2007 Linda J. Rieg 1238 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Wasington Adventist Hospital Takoma Park If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 217-70-3370 M XX F Jun 11 1960 Country Wash., D. Usual Residence of Decedent 10d. Inside City Limits ě 10a. State 0b. County 10c. City, Town or Location Maryland Prince Georges 1XX Yes 2 No or 28a-f show Brentwood traumatic event, the Medical Examiner must be notified at once, Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-5 sho Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3507 Allison St. 20722 USA Funeral 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 Married Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No Yes Specify: White Widowed Divorced f Yes, Give Year Yes No specify: 4 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 12 0 Short Order Cook Generous Joe's 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anthony A. Rieg Doris Farabaugh Be 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith A. Rieg 38174 Beachwood Ct. #17 (Sister) Frankford, Delaware 19945 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date Baltimore, crematory or other place) or other Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 11/6/07 Beltsville, MD tant Donation 5 Other Specify 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature of Funeral Service Incenses 9013 Annapolis Rd. Lanham, MD 20706 Approximate Interval art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Between Onset and 'Medical Death a. Complications of liver cirrhosis Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical the attending physician a ned for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ. Yes 2 No 3 Probably 4 V Unknown Completed peen 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? ✓ Yes 2 1 V Yes 2 No certificate neral Director: After this certifi filled in by the funeral director, 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 examiner? Other4 Nursing Home 5 Inpatient 2 V ER/Outpatient 3 1 Yes No 28a. Date of Injury (Month, Day, Year 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 1 V Natural Yes 2 Pending hours after death 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) within 24 hours at To the Funeral I determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DHMH 17 Rev 1/2001

31. Date filed (Month, Day 0) State Registrar

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

29b. Signature and title of certifie

Urus 2

Ana Rubio MD.

32. Registrar's Sign

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 2, 2007

			Please	Type or Prin							-	
			For State Registrar	State of Ma	aryland / I	-	rtment of r tificate of		vientai riy	giene Reg. No.		37385
à	Physici	en	1. Decedent's Name (First, Middle, L						2. Date of De Month	Day		3. Time of Death
	/Medic	al	RUBY 4a. Facility Name (If not institution, gr	Zella ive street and number)	- F		LEMAN 4b. City, Town, c	r Location of Death	11	08 4c.	2007 County of Deal	1030
	EXAIIIII	iei	WMHS-BRAD	DOCK CAMPUS			CUMBER		les et de		LLEGANY	
JK.	Funeral Director		5. Social Security Number 6. 219–03–9778 Usual Residence of Decedent		e (In yrs. last bii 9	(Month Do					_ Co	thplace (State or Foreign buntry) t Virginia
	Maryland 1-f show ified at	tor	10a. State MD. 10b. County Allega	any	10c. City, Tow Wes		ation port					10d. Inside City Limits 1 □ Yes 22110
	th with the 23a or 28 1st be not	al Director	10e. Street and Number 21323 Donna St.	•			10f. Zip Code 21562	2		Unit	zen of What Co ted Sta	tes
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiane. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medk al Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ I If Yes, Give Year or Dates:		If	/as Decedent of H Yes, specify Cub ☐ Yes 2 ANo	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		Specify:	e, etc. hite
5-0	"natur	leted	15. Decedent's l (Specify only highest g	Education grade completed)	16a	. Decede (Give k	ent's Usual Occup ind of work done	oation during most of wor d)	king		nd of Business	Industry
7121	withir jiene.	Be Completed	Elementary/Secondary (0-12) unknown	College (1-4or 5	5+)		memaker	u)		Hou	ısework	
Maryland 21215-0036	be de eve	To Be C	17. Father's Name (<i>First, Middle, Las</i> Herbert	Wolfe				18. Mother's Nan Cora	ne (First, Middle Le		Surname)	
	ges 1 and 2 should nt of Health and Mer I if item 27 is marke or other traumatic		19a. Informant's Name/Relationship Gary Riggleman/		2	1323	Donna S	and Number or Ru St., West	ernport	, Mai	cyland	21562
Baltimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Control of the Control		cemete	t Ce	ition (Name of atory or other pla metery	200	7	Mooi		West Virgin
Balt	permit. Page Department of Important: If any injury or once.	21. Signature of Funeral Service Licensee 22. Name a 111 Ct						ess of Facility B				d 21562
¥	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on each li	the death. Do ne. Le My a consequence		0	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
8760,	Physician: The law requires that the death certificate be executed and this certificate has been signed by the attending physician and an air director, page 2 should be detached for use as the burial-transit as	lical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	a consequence a consequence a consequence	of):	PRFERLY	Disfas	É			shout iv year.
P.O. Box 68760,	the death certificate by the attending physiciched for use as the b	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal deat		Ectopic pregnanc Other (specify) _	у			23d. Date of de Month	livery Day Year
	luires that the de n signed by the a lid be detached f	by	Part II. Other significant conditions									o the cause of death?
Records,	The law require te has been si- age 2 should b	Completed	CONGESTIV	I HEART	FAILUR	e ·			24a. Was auto perf 1 Yes		prior to death?	utopsy findings available completion of cause of
Viital	cian: ertifica ector, p	Be C	25. Was case referred to medical examiner?	Hospital:			Ott	26. Place of Dea				
ō	Ing Afte une	ion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigati	28a. Date of Inju	ıry 28b.	utpatient Time of Injury	28c. Inju		łome 5 ☐ Res 28d. Describe			ecify)
Divisi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not determine	be 28e. Place of inj	ury - At home, fa ic. (Specify)	arm, stre	et, factory, office		28f. Location City or To	(Street an own, State	nd Number or R	ural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying to the control of th	Physician: To the best caminer: On the basis of and manner st	of examination a	nd/or inv	estigation, in my	opinion, death occi	urred at the time	e, d <i>a</i> te and	d place, and du	e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. Licen	se number		29d. Da	te signed (Mon	th, Day, Year)
			30. Name and address of person wh		leath (Item 22a)	(Type 5	D 26	901		Nov	EMISICI-	1 2001
		5	MACTI+ SICINL	LM.D	900	Se	ton Di	Rive C	umber	das	d MO	21502
	Sta Regist		31. Date filed (Month, Day, Year) NOV - 9	32 Registr	rar's Signature	1						th, Day, Year) 9, 2007 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** KEID , 2007 GROTH OV /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisburg Renab 4 Nursing Ctr.
5. Social Security Number 6. Sex 7. Age (In yran ast birthday) Ulicomico lisbur If Under 24 Hrs 10 Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign If Under 1 Year **Funeral** Months Days Min 1 □ M 2 🖼 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County show Items 23a or 28a-f showner must be notified at 1 Dres 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 14. Race - American Indian 12. Was Decedent Ever in LA Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 7 is marked other than "natural", or Iter traumatic event, the Medical Examiner 1 ☐ Yes 2 ☐ No If Yes, Give filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maryland 21 If Item 27 is marked other or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) אחוו Baltimore, 20b. Place of Disposition (Name) 20c. Location - City Method of Disposition 1 Burial 2 Cremation 3 Removal from State Department o Important: If any Injury or Other (Specify) Signature of Fu eral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on such line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** eag. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of): Examiner that the death certificate be executed 20 and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9☐Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performed' 2 **□** No Division or Vital To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA r this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation 1 □ Yes 2 □ No death. 2 Accident the Funeral Director: npletely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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State Registrar

Year) 05

William H.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

vic Ave

29c. License numbe

29d. Date signed (Month. Dav. Year)

Charles George S		cker - For State	St	ate of Mary	land / I		ment of <i>icate of</i>		and	Menta	al Hygie			200	17	3738
Dhusisis		Registrar 1. Decedent's Name	(First Midd	e.Last)		Certin	reate or	Boatt	_			ate of Dea			3. Tim	e of Death
Physicia Medical Examin	er	Charles George Stoecker November 15, 2007										45 hrs				
*		4a. Facility Name (if Old York Ro		_	- Stock and Hombory							Baltimore County			unty	
Funeral		5. Social Security N	. Social Security Number 6. Sex 7. Age (In yrs				If Under 1 Year If Under 24Hrs. Months Days Hours Min.				Min	Cou			rthplace ountry)	(State or Foreign
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MD dd 2 shordth and an 27 is sumatic	Ė			oecker										1, MD 21161 Oc. Location - City or Town, State		
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Baltimore, pernit, Pages I at Department of Hei Important: If ite		4 Donation 5 Other Specify: Baptist Cemetery 2007									v ried	Moss	I, IA			
Balt permit. Depart Import injury		21 Signature of Fu	-	VarCe	wite	Tiv 1	AC 2	4 Sec	ond	i St.	., N∈	nar w Fr	eedor	m, PA	17	349
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		30. me and and		n who completed	cause of de	eath (Item 2	3a)									
4		Pamela E.	Southall,	MD Assista	nt Medio	cal Exam	iner 1	11 Penn S	treet	t, Baltim	ore, MD	21201				
	ate	31. Date filed (Mor	nth, Day, Year	1 2007	. Registrar	's Signature	x d	mels								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician 2007 18:35P M Nov 16 Velma Mary Smith

4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Frostburg Village Nursing Care
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Allegany Frostburg ff Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛱 F 90 Director Sept2, 1917 Frostburg 212-01-9670 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-1 show enty injury or other treumatic event, the Medical Examinational be notified at angles. Yes 2□No Director Frostburg MD Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21532 United States 73 Frost Village Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No ff Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 ie marked other then "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) 10 Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louis McKenzie <u>Iva L. Bittner McKenzie</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Taylor 101 Mary Court LaVale, MD 21502 sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₩Burial 2 Cremation 3 Removal from State Frostburg Mem Park11-19-07 Frostburg, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature et Funeral Service Licensee Sowers Funeral Home, P.A. Sowers 4161 Mog547 60 W. Main Street Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final 24 Hauss **Physician** Sep Sio disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, 1 or y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of by Physician/Medical Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) hours after death. uneral Director: After this certificate has been signed by the a ly filled in by the funeral director, page 2 should be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 No Lemus 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed Lusu 1 Yes 2 1No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 210 No 2 ER/Outpatient 3 DOA 1 Yes 1 [] Inpatient 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours a To the Funerel (29a. Certifier 1 🗘 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 125638 Nowember 17, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frotleng Maryland 21532 SAULNOUS CHANG CHANG 4 Broadway 31. Date filed (Month, Day, Year) NOV 2 1 2007 Registrar's Signature State Registrar

			For State Registrar	,	laryland / Del	ertificate of		Reç	1. No.2007	37389			
	Physicia		Decedent's Name (First, Midd PHILIP RY.)					2. Date of Death Month NOVEMBER	Day Year 5 2007	3. Time of Death 5:50PM M			
) ~	/Medic Examin		4a. Facility Name (If not institution	ion, give street and number	-)		r Location of Death		4c. County of Deat	h			
			6680 REESES 5. Social Security Number		ge (In yrs, last birthda	SHERW(If Under 24 Hrs.	8. Date of Birth	TALBOT 9. Birthplace (State or Foreign Country)				
	Funeral Director		214-96-5463	1 X M 2□F	26 Yrs.	Months Days	Hours Min.	NOV. 16	, 1980 MA	RYLAND			
1 5-UU30 In 72 hours after death with the Maryland "matural", or Items 23a or 28a-f show edical Examiner must be notified at		Usual Residence of Decedent 10a. State 10b. Count	ty	10c. City, Town or	Location				10d. Inside City Limits				
	Director	MD T	FALBOT	SHE	RWOOD		1 □ Yes XXNo						
		10e. Street and Number 6680 REESES I	DRIDE BUTD		10f. Zip Code	.665	109	g. Citizen of What Co USA	untry?				
	deam	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 1:	3. Was Decedent of H If Yes, specify Cub		pecify Yes or No-	14. Race - Ame Black, Whit				
ဗို	, or Ite	by Fu	1 Never Married 2 Ma 3 Widowed 4 Divorce	arnied 1 ⊟ Yes 2 🗖 If Yes, Give	No	1 ☐ Yes 2 X No		, , , , , , , , , , , , , , , , , , , ,	- 00	ITE			
3-003p	z nour natural ical Ex		15. Decede	ent's Education hest grade completed)	16a. De	cedent's Usual Occup	pation during most of work	kina 1	 6b. Kind of Business/	Industry			
	_ ; 6	Completed	Elementary/Secondary (0-12)		(5+) I	ve kind of work done DO NOT use retire VER WORKET			NEVER WORKED				
0	Hyg Hyg sther	0 1	17. Father's Name (First, Middle				18. Mother's Nam	ne (First, Middle, M	*				
		To B	ROY K. SADLI					EN K. LOW					
Mar	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		19a. Informant's Name/Relation ROY K. SADLER			0 BOX 110 ,			City or Town, State, $oldsymbol{71}$	zip Code)			
more,	of Hea		20a. Method of Disposition	n 3 □Removal from Stat		sposition (Name of rematory or other pla	ce)	Date 2	Oc. Location - City or	Town, State			
_	men ant: ury		4 □ Donation 5 □ Other	(Specify)	TILGHMA	N MEMORIAI		10/2007	TILGHMAN,	MARYLAND			
Ball	Depart Import any Inj once.		21. Signature of Funeral Service	01 1.	2.F.S.P	22. Name and Addre FELLOWS, F	IELFENBELI	N & NEWNA EASTON.	M FUNERAL MD 21601	HOME PA			
	To de		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a										
F	Physician												
ĺ	/Medical Examiner		Due to (or as a consequence of):										
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequence of):								
	execute n and al-trans	Examiner	that initiated events resulting in death) Last C										
28/60	ficate be executed j physician and ts the burial-transit	edical E											
	± 50 %	/Med	IF FEMALE:	23c. If yes, outcom	ne pf pregnancy				23d. Date of de	livery			
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л О	hat the de d by the a letached i	Phys	9 Unknown	acco use contribute t	contribute to the cause of death?								
Vital Records,	fuires that signed I ild be det	d by	1 TVes 2 TMO 31										
ဝ၁	law require as been sig 2 should t	Completed						24a. Was an	nior to	utopsy findings available completion of cause of			
5	s certif	To Be	25. Was case referred to medie examiner? 1 ☐ Yes 2 ☑ No	Hospital:	tient 2 ☐ ER/Outpa	tient 3 DOA Ot	her:	ith <i>(Check only one</i> lome 5 ⊡ Reside		ecify)			
Division or	ding Phys 1. After this funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pend	28a. Date of Ir		28b. Time of 28c. Injury at 28d. Describe how injury occurred							
1810	Attendl death. ctor: A y the fu	icati	2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Coul	stigation	njury - At home, farm,]Yes 2□No	28f. Location (Str	eet and Number or R	ural Route Number,			
2	alor As after al Director As al Director By al Director By al Director By al in by	Certification:	4 ☐ Homicide dete	building,	etc. (Specify)			City or Town	, State)				
	To the Hospital or Attending Physician: within 124 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (29a. Certifier 1 Certification (Check only one)	ying Physician: To the becal Examiner: On the basis and manner	of examination and/o	eath occurred at the rinvestigation, in my	time, date and place opinion, death occu	e, and due to the ca urred at the time, da	use(s) and manner a ate and place, and du	s stated. e to the cause(s)			
	To the within 2 To the comple	Med	29b. Signature and title of certi		Siaibu.		se number		d. Date signed (Mon				
	2 -		> Kuryell	a. Suy		H4	1581		11-8-20	07			
	9		30. Name and address of person	an who completed cause of		ope, Print) mb	2160	1 Luss	ell A. Sch	07 billist D.O.			
	Sta Regist	ate	31. Date filed (Month Day, Ye,		strar's Signature	~ ~ ~ ~ ·				,			

		•	For State Registrar	State of Marylar			te of Death		Reg	ene ^{3. No.} 2 A A 7	27200		
	Physici	_	1. Decedent's Name (First, Middle, Last) Elizabeth Frances Sonnenberg 2. Date of Death V										
	/Medio	-	45 City Town or Location of Death 14c. County of Death										
Ì	Funeral Director		5. Social Security Number 220-28-7346 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 1 Months Days Hours Min. (Month, Day, Year) 4 Pril 11, 1930 9. Birthplace (S Country) April 11, 1930 April 11, 1930										
	ryland how at		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits		
5-0036 72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	8a-f sl	Director		lontgomery		-	er Spring		10	g. Citizen of What Co	1 Yes 2 No		
		10e. Street and Number 2804 Parker Aven	iue	10f. Zip Code 10g. Citiz						ountry :			
	irs after death	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		edent of Hispanic Origin ecify Cuban, Mexican, I 2X No Specify:	n? (Specify Puerto Ric	Yes or No- an, etc.)	14. Race - Ame Black, Whit Specify: Whit	e, etc.			
Maryland 21215-0036	be filed within 72 hountal Hygiene. d other than "naturalevent, the Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	kind of w DO NOT	ual Occupation york done during most o use retired) lemaker	of working	1	6b. Kind of Business.	/Industry		
d 2	illed v Hygie other i	Be Co	17. Father's Name (First, Middle, Last)		1	aiden Surname)	****						
ylar	should be Ind Mental Is marked o	To E	Ross Farrar	er	City or Town, State, Zip Code) rham, NC 27707 Oc. Location - City or Town, State Alexandria, Virginia Home Inc. 1ver Spring, MD 20901 st, Approximate Interval Between Onset and Death								
Mar	d 2 th all		19a. Informant's Name/Relationship (T) Christine Malone		19b. Maili	_							
ore,	of H		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	20b. Removal from State	Place of Dispo cemetery, cre Metrop	osition (N matory o	Oc. Location - City or	Town, State					
Balti	permit. Page Department i Important: if any injury o		21. Signature of Funeral Service Licens	Ood							ng, MD 20901		
)	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused the deane cause on each line. a. Carcinoma of Due to (or as a conse	Esoph			ardiac or re	espiratory arre	st,	Approximate Interval Between Onset and Death 1 Year		
68760,	ificate be executed by physician and stree burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Finter Underly in Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.									
O. Box	death cert e attending d for use a	Physician/Med	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 23d. Date of delivered Month Mon								elivery Day Year		
ds, P	uires that the de signed by the Id be detached i	þ	Part II. Other significant conditions co		d tobacco use contribute to the cause of death? ☑ Yes 2 ☑ No ૐૐProbably 4 ☑Unknown								
or Vital Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed							24a. Was an autops perform 1□ Yes 2	prior to death?	utopsy findings available completion of cause of		
Vita	iclan: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	TER/Outpotio	nt 201	26. Place of						
	Jing After fune	ion: To	27. Manner of Death 12 Natural 5 Pending	I Impatient 2 Envolupatient 3 Don 4 Norsing nome Sharesion						dence 6 LiOther (Specify) how injury occurred			
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At I building, etc. (Spec	njury - At home, farm, street, factory, office 28f					Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital of within 24 hours af To the Funeral Completely filled i	Medical C	29a. Certifier (Check only one) 1	vsician: To the best of my kr Iner: On the basis of examir and manner stated.	owledge, dea nation and/or i	nvestigati	on, in my opinion, death	l place, an h occurred	at the time, d	ate and place, and du	ue to the cause(s)		
	Tot Tot	Ä	29b. Signature and title of certifier	29b. Signature and title of certifier D12121 29c. License number D12121									
	\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \		George F. Sengst	On Name and address of person who completed cause of death (Item 23a) (Type, Print) George F. Sengstack, MD 3929 Ferrara Drive, Wheaton, MD 20902									
	St	ate	31. Date filed (Month, Day, Year)	32 egietrar's Sigr	nature	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVE MBE 03,2001 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER VASHINGSO OF ROCKVILLE MONTGOMERY CAD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, **Funeral** (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2√2 F 065-46-9113 Director 81 Aug.6,1926 Románia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 ☐ Yes 2€ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 311 Warrenton Drive 20904 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ White 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) High School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Avram Segal Paulina Bercovici 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Schonfeld (Son) 311 Warrenton Dr., Silver Spring,MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of connetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from Werdale Park Crem 4 □ Donajion 5 □ Other (Specify) 11/5/07 Riverdale, MD of Funeral Service Lice 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signatur 246 N. Washington St, Rockville, MD 20850 23a. 1 art1. Enter the dise shock, or heart failur. lications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SUBARACHNOIC HEMMOR **Physician** /Medical Due to (or as a consequence of): Examiner TRONN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopie plegnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 **N**o 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s certificate 1□ Yes 2 HNO 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Medical Certification: To Be 26. Place of Death (Check only one) Other: 4²⁶ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1**X**Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 2. Accident 5 ☐ Pending investigation PATIENT ours after death, neral Director; / filled in by the fi OCt 11 2007 10:25 AM 1 Tes 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

NVRSING HOME

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner steted.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ROUGH HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ROUGH HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ROUGH HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

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10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner steted. 6 ☐ Could not be 3 Suicide 4 Homicide 6105 Montrose within 24 hours at To the Funeral D (Check only 29b. Signature and fitle of certifier 29d. Date signed (Month, Day, Year) anbour NOVEMBER 03, ZOOT

State Registrar 31. Date filed (Month, Day, Year,

06

TNYM.D. 6121 MONTROST RD, PRIXIVILE, 4D 20752

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 9 1 37392 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yeer Szoltek Month M **Physician** Mildred 9:50 dm 04 2007 /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Coastal Hospice at the Lake Salisbury If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** 1 M 200 85 220-12-5959 Director 11/19/1921 Maryland Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 28a-f show 1X Yes 2 □ No Md. Ocean City Director Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21842 USA 5301 Atlantic Ave. Unit 1S by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ŽÎNo If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 → No Specify: 3 MWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Army Corps Of Engineers Accounting permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Hlavaca Matthew Kriz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Hahn/Daughter 5301 Atlantic Ave. Unit 1S Ocean City, Md. 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Buriat 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 11/8/2007 White Marsh, Md. Holly Hill Memorial 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. MOO845 4112 Old Columbia Pike Ellicott City,Md. 21043 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervat Between Onset and Death shock, or heart failure. List only Immediate Cause (Finat disease or condition resulting in death) Renal **Physician** 4 mentes /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 Yes 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? the funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hespite 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-04-2007 D 29505 Gono 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD Z1801 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:45 P.M October 20, 2007 William Edward Smouse /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Garrett Garrett County Memorial Hospital Oakland Birthplace (State or Foreign Country) If Under 24 Hrs. Hours Min. If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Months Days 1**x** M 2□ F Apr 10, 1933 213-28-7413 74 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Director Accident MD Garrett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21520 USA 33 Spear Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced 4/28/49 white Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Barber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude V. Welch William Henry Smouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21520 Ruth I. Smouse/wife 33 Spear Rd., Accident, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oakland Cemetery Oct 24, 2007 Oakland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A., P.O. Box 275 Part1. Enter the diseas shock or heart failure. (000) CC 179 Miller St., Grantsville, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Physician/Medicai Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 | Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi 10,20,7. D23979

Examiner use as the burial-transit The law requires that the death certificate be executed To the Funerst Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trar Division of Vital Records, P.O. Box 68760 death. ie Hospital or Attendi n 24 hours after death. ie Funers! Director: A To the I within 2

Physician

/Medical

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturs!, or thems 23e or 28e-f show eny Injury or other treumatic event, the Medical Examinat must be notified at

Baltimore, Maryland 21215-0020

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Goralski, M.D., 311 N. Fourth St., Oakland, MD 21550 Robert A. 31. Date filed (Month, Day, Year) 9

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#19A Per FH State of Marylar State Registrar 11/5/07 AACO HEALTH DEPT. OM Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ralph J. Sorrentino 3:48 Ам 29 2007 Oct /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 244 Moreau Court Severna Park Anne Arundel 5. Social Security Number 101–03–1921 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1XM 2□F 93 Director Aug 19, 1914 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at any onee. I Hygiene. other than "natural" or Items 23a or 28a-f show rent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Severna Park Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 244 Moreau Court 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give WWII Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: δ Specify: 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Internal Revenue Elementary/Secondary (0-12) College (1-4or 5+) Special Agent Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julius Sorrentino Rose Campsi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores A. Booker/ Daughter 514 Martingale Lane, Arnold, Maryland 21012 Dolome 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Date 20c. Location - City or Town, State 03, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery Brentwood, Maryland 4 Donation 5 Other (Specify) 2007 21. Signulate of Juneral Service Like 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146 rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest k, or neart failure. List bury one cause on each line. Approximate Interval Between Onset and Death BLANDER mmediate Couse (Final disease or ondition resulting in death) **Physician** YEVAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a □Yes 2□No 9 Unknown 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
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To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home % Residence 6 Other (Specify) 1 Yes 2 No <u>L</u> 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1∕⊠Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) the and manner stated. 29b. Signature and title of fertifier 29c. License number 29d. Date signed (Month, Day, Year) D08118 October 29 LW7

State

Registrar

31. Date filed (Month, Day, Year)

SIMMURY

WATKINS m 32. Registrar's Signature

OCT 3 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		30. Name and address of person v Saadia Husain,	who completed cau	use of death (Item 307 Be1	n 23a) (Type Pre Re	Print) oad, Silv	er Sp	ring,	MD				
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Registrar
DHMH 17 Rev 1/2001

State

Martin McGrievy, M.D.,

06

2007

31. Date filed (Month, Day, Year)

9901 Medical Center Drive, Rockville, MD 20850

			1 - State of Maryland / Department of Health and Certificate of Death		200-	77207			
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Maryland 21215-0036		မ	James William Murphy , Sr. Betty M		ule				
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		A	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Oal	land w			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08631 State of Maryland / Department of Health and Mental Hygiene Johnathon W. Tichinel 2007 37398 Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day November 6, 2007 Physician/ William Tichinel Johnathon Mুপুটা≋al Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Allegany Cumberland Western Md Health System 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Oct 12 1980 Foreign Maryland If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 236–19–2293 **Funeral** Days Min. Oct. 12 1980 Months Director 1 X_M 2 F Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State Piedmont WV. Mineral 28a-f shov Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Menlal Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 88 East Hampshire St. 26750 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 1 Yes 2 X No Yes 2 X No specify: Divorced If Yes, Give Year þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Coal College (1-4 or 5+) Elementary/Secondary (0-12) Miner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gwendolyn McIntosh Tichinel Bobby Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brandi Tichinel/ wife 411 Spruce St., Westernport, Maryland 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition 11/10/ crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2007 Philos Cemetery Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7- Warne 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Medical a. Contact Gunshot Wound of Head Immediate Cause (Final disease .aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Hospiral or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED 68760 IF FEMALE: 23b. Was decedent pregnant in the 23c, If yes, outcome of pregnancy Fetal death 3 Ectopic pregnancy Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o δ 24a. Was an Records, has been s autopsy performed? ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Nursina Home 5 examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 1 ✓ Yes

20c. Location - City or Town, State Westernport Maryland Boal Funeral Home 111 Church St., Westernport, Maryland 21562 Approximate Interval Retween Onset and 23d. Date of delivery Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗸 Yes Residence 6 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury Subject shot self Nov 5, 2007 2108 hrs Yes 2 ✔ No 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 88 East Hampshire Street , Piedmont, WV (Specify) Single Family Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number November 7, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 32 Registrar's Signature **ORIGINAL**

1345 hrs

10d. Inside City Limits

1 X Yes 2 No

white

of Vital After this To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A Division neral Director: / filled in by the f

27. Manner of Death

3 🗸 Suicide

29a. Certifier 1

Medical

State

Registrar

Natural

Accident

Homicide

29b. Signature and title of certifier

Laron Locke MD.

31. Date filed (Month, Day, Year)

NOA

OCME

9 2007

Pending

Uri

Investigation

Could not be

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 2 Nov 2007 12:45 AM FRANCIS LEWIS WAGENBLATT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Genesis HealthCare - The Pines Talbot Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1**X** M 2□ F 85 CT APR 12, 1922 Director 045-16-3734 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23s or 28a-f ehow empinjury or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 1 Yes 2 No EASTON MD TALBOT Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 306 FALL LANE 21601 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1∰Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. ancis Wagenblati Maryland 21215-0036 1 Never Married 2 Married 1 ☐ Yes X No Specify: Specify: þ 3X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HARDWARE MANUFACTURING 0 MANAGEMENT 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FREDERICK JOSEPH WAGENBLATT ELEANOR SAVAGE Franci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FREDERICK JOSEPH WAGENBLATT/SON 306 FALL LANE, EASTON, MARYLAND 21601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION CTR 11/3/2007 STEVENSVILLE, MD 21. Signature of Foneral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Kenu /Medical Due to (or as a consequence of) Examiner neers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner ate has been signed by the ettending physicien end page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ exceptorescular accident 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident or Attendefer death Director: 6 Could not be determined 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours eff To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type_Print) DUTCHMAN'S LAND 6+VA MICHAEL MD 610 31. Date filed (Month, Day, Year) State 05 Registrar

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DHMH 17 Rev 1/2001

7-08302 Brad Wolfe

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Baltimore, Maryland 21215-0036	72 hou	ted	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occup	ation during most of work	ina	16b. Kind of Business/I	
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month NOVEMBER 7:00 AMM ALTA MAE WESTON 2007 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT HOSPICE HOUSE TALBOT EASTON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JAN 6, 1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2X F 90 Director 213-38-2696 ND Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic evant, the Nedical Examinar must be notified at 1 XYes 2 ☐ No MD TALBOT EASTON Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 545 CYNWOOD DRIVE, APT. 212 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or ther any injury or other traumatic evant. The Martical Ferri 1 ☐ Yes ANNO If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ALFRED M. HANSON ပ္ ELSIE LAVINA SPENCER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JON WESTON/SON 5920 BETHLEHEM COURT, ROCKVILLE, MD 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 □ Cremation 3 □ Removal from State ARLINGTON NATIONAL * 4 ☐ Donation 5 ☐ Other (Specify) 11/14/2007 ARLINGTON, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Ostnowsh. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 2[] No 1 ☐ Yes 2 2 No 1 TYes Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPIC 2 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number sul 30. Name and address of person who completed cause of death (16m 23a) (Type, Print) 6 WILLIAM H. WOOD, JR. M.D. 501 DUTCHMANS LANE, EASTON, MD 21601 31. Date filed (Month, Day, Year) NOV 0 2 2007 3 Registrar's Signature State Registrar

			For State Registrar	State of N		epartment o		nd Mental Hyg	giene 007	37403
	Physici /Medi		1. Decedent's Name (First, Middle Emm q	Jane V	Vyche			2. Date of Dea Month Octobe	29, 2007	
	Examir	ner	4a. Facility Name (If not institution Washingto	n Adven	tist Hosp	ital Tak	oma Pa	rk	4c. County of Dea Montgo	mery
	Funeral Director		5. Social Security Number 223-40-7493 Usual Residence of Decedent	6. Sex 7. A 1 □ M 2 X F	Age (In yrs. last birtl 74 Y		ays Hours	Min. 8. Date of Birth (Month, Day	// Year) 9. 8II	thplace (State or Foreign buntry)
	ith the Maryland or 28a-f show	ctor	D.C. 10b. County		10c. City, Town	or Location	4			10d. Inside City Limits 1 Yes 2 □ No
	eth with the 23a or 28	Funeral Director	10e. Street and Number 6141 Kansas	Avenue,	N. W.	10f. Zip Co	2001	(United	States
9003	within 72 hours atter deeth with the Maryland ene. then "natural", or items 23e or 28e-f show the Madisal Examiner riust be notified at	by	11. Marital Status 1 ☑ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	ti Yas Give	s? ₹No	13. Was Decedent II Yes, specify 1 ☐ Yes 2		in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, Whi Specify: B	te, etc.
21215-0036	filed within 72 h Hygiene. ther then "nete	Completed	(Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or		Decedent's Usual O Give kind of work of life. DO NOT use n	loné during most detired)		Nursi	,
Maryland	Mental Mental Brked o	To Be	17. Father's Name (First, Middle, Frank Wycl	ne			Mir	's Name (First, Middle, 7nie Mas	ion	
	s 1 and 2 sho of Health and item 27 is my other traum		19a. Informant's Name/Relations Minnie Tor 20a. Method of Disposition		er) 123	-	r Rd., 5	Stony Cre		3882
altimore,	Page nent o ant: # ary or		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	pecify)	· Wyche	Family Ce	metery No	2007	Stony Cree	k, Va.
Ba	Depertrimporte any injector.		21. Signature of Funeral Service Surin A 34,0 23a. Part 1. Enter the disease I in the service of heart failure I interest of the service of	complications that cause	61 ed the death. Do no	J.M. Will 102 Sou	kerson F thave,	Funeral Est Petersbur ardiac or respiratory ari	rablishmen 19, Va. 238	7 Inc. 03 Approximate
	Physician /Medical	:	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Athe	rosci	erotic		elan Dis		Interval Between Onset and Death
8760,	ate be executed by sicien and be burial-transit be burial-transit by	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. Caro Due to (or a	is a consequence of	Arrhy	thmic			
P.O. Box 6	that the death certition and by the ettending plant detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Vo 9 □ Unknown		e ol pregnancy 2 Fetal death at time ol death	3 ☐ Ectopic pregn 5 ☐ Other (specif			23d. Date of de Month	livery Day Year
	w requires thet the been signed by the should be detache	by	Part II. Other significant condition	ns contributing to death	but not resulting in	the underlying caus	e given in Part I.		ebacco use contribute to es 2 □ No 3 □ P	5.0
	The law ate has b page 2 sl	e Completed	25. Was case relerred to medical						sy prior to death? 2 No 1 Yes	utopsy lindings available completion of cause of
of Vil	Phys this ral dii	To B	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpat	iury 28b. Ti		Other: 4 Nurs	of Death (Check only or sing Home 5 Resid		ocify)
	il or Attending latter death. Director: After	Certification:	1 Natural 5 Pendin 2 Accident Investit 3 Suicide 6 Could I 4 Homicide determ	gation on the lined 28e. Place of Ir	njury - At home, farretc. (Specify)	М	Injury at Work? 1 _ Yes 2 _ No		treet and Number or R n, State)	ural Route Number,
	To the Hospital or All within 24 hours atter or To the Funeral Directompletely tilled in by	edicai C	29a. Certifier (Check only one) Certifyin 2 Medical	g Physician: To the bes Examiner: On the basis and manner s	st of my knowledge, of examination and stated.	death occurred at If for investigation, in	ne time, date and my opinion, death	place, and due to the or occurred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
)	To the To the Complet	M	29b. Signature and title of certifier	OMO		29c. Li	\$769	2	29d. Date signed (Mon.	1, 2007 11/10, 20912
5	B 5		30. Name and address of person Drawry Jan	who completed cause of	death (Item 23a) (T	ype, Print)	Carrol	11 Ave. Tako	ma Park,	Md. 20912
100 A	Sta Registr	_	31. Date filed (Month, Day, Year)	6 2007 32. Regist	trar's Signature	Sperte		,		

			for State Registrar	State of Ma	aryiano	•	artment of F rtificate of	nealth and N Death	nentai myg R	ene 200	7 37404		
	Physici	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year											
	/Medi	cal	Joseph W.	Woodan	rd		45 Ott. T	-1	Nov. 7,		9:55 P M		
\$	Examir	ner	4a. Facility Name (If not institution, given 324 Hazelhurst	,			Swan	r Location of Death		4c. County of E			
	Funeral		5. Social Security Number 6. S	Sex 7. Age	e (In yrs. las	t birthday)	If Under 1 Year		8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)		
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	and ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Lo	cation				10d. Inside City Limits		
	Mary Ifed a	tor	WV Miner	al		Keys	er				1 X Yes 2 □ No		
	th the	Jirec	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wha	t Country?		
	ath wi	ral	88 Orchard Stree				267			USA			
	items	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent 8 Armed Forces?		13. \	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.		
920	urs af al', or Exami	by	3 X Widowed 4 □ Divorced	1 XYes 2 □ N If Yes, Give Year or Dates:	WWII		1□Yes 2¶X No	Specify:		Specify:	White		
2-0	72 ho natur dical l	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	dent's Usual Occup	pation during most of work	kina I	16b. Kind of Busin	ess/Industry		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed by	Elementary/Secondary (0-12)	College (1-4or 5				during most of work d)	1	II a m a 1 a	Danidan		
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ary	2 should and Mer Is marke aumatic	-	19a. Informant's Name/Relationship	Type. Print)		19b. Mailin	ng Address (Street	and Number or Rui	ral Route Number	City or Town, Sta	te, Zip Code)		
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Baltimore,	of of		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐		cerr	netery, crer	sition (Name of natory or other place	ce)		20c. Location - City	,		
ĦΞ	Part ury		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice		Sca		.1 Cremao 2. Name and Addre	rty 11/9		Cumberla			
Ba	permit. Departr Imports any Inj		Van HALL	lome Ke	O. Box 9 yser, WV	26726							
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death.	Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death		
B	Physician / /Medical	ĺ	Immediate Cause (Final disease or condition resulting in death)	c.O.P							Years		
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Вох	eath certifi attending for use as	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			75 - tania			23d. Date of	delivery		
	ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at 9□Unknown			Ectopic pregnancy Other (specify)	y 		Month	Day Year		
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or V	Physician; r this certific ral director,	To	1 ☐ Yes 211 No	Hospital: 1 Inpatie		/Outpatien		4 □ Nursing Ho	ome 5 X Reside	nce 6 □Other (Specify)		
o U C	ding F h. After funera	ion:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		Bb. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe ho	w injury occurred			
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<u>S</u>	s after al Dire	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)				City or Town	, State)			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical (29a. Certifier 1 X Certifying Pl (Check only one) 2 Medical Example (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examination	edge, death n and/or inv	n occurred at the til vestigation, in my o	me, date and place, opinion, death occur	and due to the carred at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)		
	To th within To th	Me	29b. Signature and title of certified	16			29c. Licens	e number	25	9d. Date signed (M	Ionth, Day, Year)		
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	4	シア	30. Name and address of person who							0.1 = = =			
	Sta	2D	Dr. Ken Buczynsk 31. Date filed (Month, Day, Year)		ar's Signatur		h St., 0	akland, M	aryland	21550			
	Registr			2007	020		gard's o						

			1 - For State Registrar	State of Maryland	/ Department of I Certificate of	Health and Me	•	7 11 11	37405
	Physic /Medi Examii Funeral Director	cal	1. Decedent's Name (First, Middle, Last 4a Facility Name (If not institution, give 0.05 0.05 5. Social Security Number 185-40-6724 Usual Residence of Decedent	Webb street and number) Ce at the La	ake Sa	or Location of Death	11 00	Day Year 2007 Ic. County of Death 9. Birth, Cou	nica
	ith the Maryland or 28a-f show	Director	MD Worceste 10e. Street and Number		Town or Location n City 10f. Zip Code		-	Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 🖾 No
920	d within 72 hours after death with the Maryland jene. r then "naturel", or teme 23a or 28a-1 show the Medical Exam, we must be notified at	by Funeral	12106 Angler Rd. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	21842 13. Was Decedent of If Yes, specify Cub 1 Yes 2X No	Hispanic Origin? (Specifican, Mexican, Puerto Rie Specify:		SA 14. Race - Amen Black, White, Specify: Whit	, etc.
121215-0036		Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation le completed) College (1-4or 5+)	16a. Decedent's Usual Occul (Give kind of work done life. DO NOT use retire Activity A	during most of working d) SSISTANT		Kind of Business/In	
Maryland	2 should be fill and Mental H is marked off summatic even	To Be	17. Father's Name (First, Middle, Last) Richard Price 19a. Informant's Name/Relationship (T)		19b. Mailing Address (Street	18. Mother's Name (I Catherine and Number or Rural F	M. Adams		o Code)
Baltimore, N	permit. Pages 1 and 2 should be filed Department of Heath and Mental Hyg Important: If item 27 is marked othe- any injury or other traumatic event, any injury or other traumatic event,		Ken P. Webb / Hus 20a. Method of Disposition 1 Burial 2 Ocernation 3 F 4 Donation 5 Other (Specify)	20b. Plac	12106 Angle ce of Disposition (Name of netery, crematory or other pla Henlopen Crei	ce) Dat	e 20c.	MD 21842 Location - City or To ankford,	
Bali	Departi Depart Import any in		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	COSTOO lications that caused the death.		iam St., Be			Approximate Interval Between
760,	Physician and // // // // // // // // // // // // //	lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		nce of):	out OF	- BRFA	-57	Onset and Death
P.O. Box 68	The law requires thet the death certifica ate has been signed by the attending ph page 2 should be detached for use as if	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnance 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 Ectopic pregnance	у	sterio	23d. Date of delive Month	ery Day Year
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Division of Vital Records,	ding Phy n. After this funeral d	ation: To B	examiner?	1	WOutpatient 3 DOA Sb. Time of Injury M 1 1	er: 4 Nursing Home			(y)
Divis	or A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)			Location (Street a City or Town, Stat	te)	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) Certifying Physical Learning	sician: To the best of my knowle ner. On the basis of examination and manner stated.	edge, death occurred at the tire and/or investigation, in my o	ne, date and place, and pinion, death occurred	d due to the cause(: actine time, gate ac	s) and manner as s in place, and one to	stated. u the cause(s)
	of Too	Σ	29b. Signature and utler of certifier		29c. Licens	s number 5 2 41 0		ate signed (Month, $y - 6 - 0$	_
B	H3 Sta	_	30. Name and address of person who co HWY M AR 31. Date filed (Month, Day, Year)	COA L 32. Pegistrar's Signature	3a) (Type Print)				1021202
	Registr		NOV 0 7 200	17 Brew &	Sporte				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08544 State of Maryland / Department of Health and Mental Hygiene Angel Asimenios 37406 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day November 3, 2007 0810 hrs Medical Examiner Angel Asimenios 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 1933 Eastern Avenue 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7 Age (In vrs. last birthday) 5. Social Security Number un 6. Sex **Funeral** Months Days Hours Min Director CountryMaryland Jan 2, 1960 M 2 X F 47 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 Y Yes 2 No 28a-f show Baltimore MD death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 21231 USA 1933 Eastern Avenue 23a or Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes 2 X No f Yes. Give Yee Yes 2 No specify: Specify Widowed 4 Divorced white 2 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' injury or other traumatic event, the Medical 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gloria Ziolkowski Spiro Asimenois 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u> Annette A</u>si<u>meni</u>os/sister 346 Upperlanding Road Essex, MD 21221 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in7state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Funer J Service License and S / Ware, Director 21201 <u>Baltimore, MĎ</u> complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or **Physician** en Onset and ailure. List only one cause on each line /Medical Death a. Methadone intoxication complicating seizure disorder Imme hate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical X UNPENDED AMENDED 11,27,28a-f, perME,g876, 2/25/08 TT the attending physician ed for use as the burial P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by þ Yes 2 No 3 Probably 4 ✔ Unknown Hypertensive cardiovascular disease Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 V No Nο 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA After this 1 ✓ Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: hours after death. uneral Director: A ly filled in by the fu Natural Yes 2 X No unk Pendina Fnd 11/3/2007 FNd 7;45 am 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 1933 Fastern Ave. Baltimore, MD Suicide (Specify) found at residence 24 hours a Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 7 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 3, 2007 O.C.M.E. tarhe 0 nos 30. Name and address of person who completed cayse of death (Item 23a)

State Registrar 111 Penn Street, Baltimore, MD 21201

Tasha Greenberg MD.
31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1- For Amend #2 Per Phy G873 11/29/OZer Efficate of Death Reg. No. ZUU 2. Date of Death Decedent's Name (First, Middle, Last)
JAMES THOMAS Day **23**, Year R **24**, 2007 BANKARD Month JR. **Physician** 6:50P M NOVEMBER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5205 COBBLER COURT BALTIMORE PERRYHALL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2 ☐ F 218-36-2479 65Yrs 9-17-1942 MARYLAND **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location MD BALTIMORE PERRYHALL 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Ex miner must be r 5205 COBBLER COURT 21128 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) item 27 is marked other than "natu other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ ELECTRICAL ENGINEER PGE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **JAMES** THOMAS BANKARD, SR. ETHEL (CHESTER) ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANET BANKARD/WIFE 5205 COBBLER COURT PERRYHALL, MD int of Health a t: If item 27 is y or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) GARDENS OF FAITH 11-28-07 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH 'ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer /Medicai Due to (or se consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 2 X No 1☐ Yes the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only only) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02435 0, death (Item 23a) (Type, Print) Name and address of person who completed 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D20, 2007 **Physician** November Norma Betty Buckley 6:00PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6391 Rowenberry Drive Unit 326 Elkridge Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 25, 1920 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 🛣 F Hours Country) MD 87 Director 214-14-8964 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6391 Rowenberry Drive Unit 326 21104 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed by 3K Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dietary 12 <u>Dietary Work</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Franklin Ward Maude Edith McCaulev 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If item 27 i any Injury or other tra once. Mrs. Mary Jean Freeman (Daughter) 5378 Smooth Meadow Way Unit2 Columbia. MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 11/24/2007 Sykesville, MD 22. Name and Address of Facility
HAIGHT FUNERAL HOME
Sykesville, MD 21784 21. Signature of Funeral Service License & CHAPEL, 4 (410)-7 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician unorea 4mos disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a ponsecuence of) if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 20 No 1 ☐ Yes 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an idemu has page 2 autopsy performe ERN this certificate G 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by determined 4 THomicide Hospital Medical 1 🗽 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Belle Bauman 5841 State

DHMH 17 Rev 1/2001

Belle

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

36245

1. Elkridge MD

29d. Date signed (Month, Day, Year)

07-08893 Bobby Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

Bobby Brown	1.	State of Marylan	o / Depart Certi:	ficate of	Death	i Wentai	rriygicho	Reg. No	. 2	007	3740
	Re	gistrar Decedent's Name (First, Middle,Last)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			2. Date of I	Death			of Death
Physician Medical Examina	-71	BOBBY BROWN					Month Novem				6 hrs
ζ		a. Facility Name (if not institution, give street and numb	per)	4	b. City, Town, or I	_ocation of D	Death	4	c. County of E		
	Ц	1735 E. 30th St.			Baltimore	If Under 2	AHrs 8 Date 0	Birth (MI		/A 9. Birthplace (State or Foreign
Funeral	5	Social Security Number 6. Sex 7.	. Age (In yrs. las	t birthday)	If Under 1 Year Months Days		Min.		1	Country)	
Director	1	237-72-3059 1XXM 2 F		60 Yrs.			09/1	7/19	47	NOR'I'H	CAROLINA
		sual Residence of Decedent	10c City T	own or Locati	on						side City Limits
w any		0a. State 10b. County	1001 0.13,1							1XX	Yes 2 No
Maryland 28a-f show d at once.	व ।	MARYLAND N/A		BALTI	MORE 10f. Zip Code			10g. C	itizen of What	t Country?	
Mary Mary	Director	0e. Street and Number			2.7	210		1	U.S.A		
r death with the Maryland or items 23a or 28a-f sho must be notified at once.		1735 E 30th STREET 1. Marital Status 12. Was Dece	dent Ever in U.S	i. 13. Wa	s Decedent of His	L218 spanic Origin	? (Specify Yes	r No-	14. Race - White,	American Indi	ian, Black,
ath wi	= 1	1 X Never Married 2 Married Armed For	ces?	If Y	es, specify Cubar	n, Mexican, F	Puerto Rican, etc.)]
er de		1 Yes Widowed 4 Divorced If Yes, Give Year	2xx No		Yes 2 XX No					BLACK	
Irs afi tural'	황	15. Decedent's Education (Specify only highest grade	completed)	16a. Deceder	nt's Usual Occupa	tion (Give kit	nd of work done se retired)	16t	. Kind of Busi	iness/Industry	
n "na al Ex	Completed	Elementary/Secondary (0-12) College (1-	4 or 5+)					- 1	3.T / 70		
5-0036 led within 7 Hygiene. I other than	ם	9th grade	l	CONS	STRUCTION	18 Mother's	Name (First, Mic	ldle, Maid	N/A en Surname)		
5-0 led w Hygie		17. Father's Name (First, Middle, Last)					LMA PER				
121 d be fill ental l arked	Be	ZENO BROWN 19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	ig Address (Stre	et and Numb	per or Rural Rout	e Number	, City or Town	, State, Zip C	ode)
D 21 should 1 and Mei 7 is mai	-1				4 W SARA			TI	4D 2122) 3	
, MD and 2 sho ealth and em 27 is	-	Ronnie Brown/Brother		Place of Dispo	sition (Name of ce	emetery,	Date	20	Oc. Location -	City or Town,	State
Baltimore, permit. Pages I an Department of Hee Important: If ite		1 X Burial 2 Cremation 3 Removal from	Jili State	rematory or o	CEMETER	v	11-27-0	, ,	BETHEL.	NORTH	CAROLINA
ti Pag tment rtant:	-	4 Donation 5 Offiner Specify: 21. Signature Conteral Service Licensee				o of Engility				HOME	D 7
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	l	1 your manay	'el	1 7 /	ILLIAM C	COULT AT	********				
Physician		23a Part Farer the disease, or complications that ca	aused the death.	. Do not enter	the mode of dying	g, such as ca	ardiac or respirate	ory arrest,	shock, or hea	art Apr	tween Onset and
edical		failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosc									Death
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ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed of earth. by the funeral director, page 2 should be detached for use as the burial - transit	\8	IF FEMALE: 23c. If yes, 1 Live II	outcome of preg	gnancy		3 Ectopic	c pregnancy		Month	Day	Year
Sox 6876(leath certificate e attending phy for use as the b	sician/N		nant at time of d		Other (Specify)				1		
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O. B at the d I by the	Phy	Part II. Other significant conditions contributing t	to death but not	resulting in the	e underlying caus	e given in Pa	art I. 23				4 Unknown
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rds requir	율						'`	autops	y	prior to comp death?	letion of cause of
e law e has ge 2 s	Completed						1	Yes 2		1 🗸 Yes	2 No
Refrest	ပို	25. Was case referred to medical			26.Pi		(Check only one				
Division of Vital Records, not retreated by the law required as after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be led in by the funeral director, page 2 should be	m	examiner? 1 Ves 2 No	Inpatient 2	ER/Outpation		Other 4	Nursing Home		Residence 6 ow injury occu		ene
of \ g Phy fiter the	2	27 Manner of Death 28a. Dat	e of Injury th, Day,Year)	28b. Time		njury at Wor	_	escribe n	bw injury deca	iiieu	
On endin ath. or: A	5	1 X Natural 5 Pending 2 Accident Investigation				Yes 2		-ation (6)	troot and Num	ther or Rural F	Route Number, City
/iSi rr Att her de hirecte in by I		2 Accident Investigation 3 Suicide 6 Could not be	ace of Injury - At	home, farm, s	street, factory, office	ce building, e	etc. 281, LC	Town, St	ate)	iber of Hara. I	,
Oital o	Certification:	4 Homicide determined (Specific					the second disease	the cause	a/e) and mann	er as stated.	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: completely filled in by the Ki			est of my knowle	edge, death or	ocurred at the time	e, date and p nion, death c	place, and due to occurred at the til	ne, date a	and place, and	due to the ca	ause(s)
To the Hos within 24 h	Medical	one) 2 Medical Examiner: On the basis and manner	stated.			ense numbe			29d. Date sig	gned (Month,	Day, Year)
	Ž				1	.C.M.E.			Novembe	er 18, 2007	7
		Mounta me 134	w								
ϕ	1	30. Name and address of person who completed ca	ause of death (Ite	em 23a) Liner 111	1 Penn Street	, Baltimo	re, MD 2120	1			
(Registrar's Sign		344						
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ian	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Deat
cal ner	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical (Center	idges 4b. City, Town, or	Location of Death Tows		4c. County of Dea	th ltimore
	1 M 2 D E	n yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y March 12	(ear) 9. Bir (Co., 1914)	thplace (State or For buntry) Maine
ctor	Maryland Baltimore	c. City, Town or Lo Luther					10d. Inside City Lin 1 ☐ Yes 2 ☐
Director	10e. Street and Number		10f. Zip Code		10g	g. Citizen of What Co	ountry?
	8401 Kellogg Court	- in 11.0	2109			U.S.A.	rises Indias
by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ★ No If Yes, Give Year or Dates:		Was Decedent of Hi: If Yes, specify Cuba 1 □ Yes 2 ☎ No	spanic Origin? (Spi n, Mexican, Puerto Specify:	ecity Yes of No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
Completed b	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	luring most of work	ing 16	Bb. Kind of Business	ite (Industry
Com	Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last)		ccountant		(First, Middle, Ma	U.S. Gove	ernment
To Be	Chester Bridges	S			auline	Fernal	d
	19a. Informant's Name/Relationship (Type. Print) Elizabeth T. Bridges Wife					City or Town, State, I lle, Mary	
	20a. Method of Disposition 2 1 ★□ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crer	natory or other place	9)	Date 20	c. Location - City or	Town, State
	4 Donation 5 Other (Specify) 21. Signature of Foreral Service Licensee	22	ge Cemete 2. Name and Addres 1050 York	s of Facility Ru		Pikesville n Funeral arvland	<u> </u>
Examiner	Due to (or as a co	onsequence of):ERFORAT	IAL INFA	RCTION			Onset and Dea
Physician/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown d. 23c. If yes, outcome pf p 1 Live birth 2 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Yea
5	Part II. Other significant conditions contributing to death but no OLOSTOMY	ot resulting in the ur	nderlying cause give	n in Part I.		cco use contribute to	\ A
Completed					24a. Was an autopsy performe	prior to death?	utopsy findings avai completion of cause 2 No
Certification: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Place of injury 28e. Place of injury 39e.		28c. Injury Work M 1 \(\)	4 □ Nursing Ho at ? /es 2 □ No	me 5 ☐ Residenc 28d. Describe how	ce 6 Other (Speinjury occurred	
cal Certi	4 Homicide determined building, etc. (S 29a. Certifier (Check only 2 Medical Examiner: On the basis of examiner)	y knowledge, death	h occurred at the tim	ne, date and place,	City or Town,	se(s) and manner as	s stated.
Medical	29b. Signature and title of certifier		29c. License			I. Date signed (Mont	
	* K. Mh		D46	356	No	vember	24,20
ate rar	30. Name and address of person who completed cause of death	7601 09	Print) SLER DRI	VE TOWS	ON. MAR	YLAND 21	1204

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₹) 1960	Physicia Medic		Ruby	ie (First, Wild	idle, Last)						B	one		2. Date of Month		Day 20 2	Year 2007	3. Time of Death
	Examin	er	4a. Facility Name ('If not institu						4b. City,	Town, o	r Location	of Death			4c. Coun	ty of Death	
		100		pkins		- M		al Cer			noi	_						
	uneral irector		5. Social Security (219-28-	0872	6. Sex	vi 2 ∏ F		e (In yrs. Ia 76	st birthday) Yrs.	If Under Months	1 Year Days	If Unde Hours	Min.	8. Date of (Month)	Birth Day, Ye	ar) 31	9. Birthp Cour	place (State or Foreigntry) MD
and	, t		Usual Residence of 10a, State	10b. Cour	ıty			10c. City,	Town or Lo	cation			<u> </u>				1	0d. Inside City Limits
Mary	f sho	jo	MD	1	1A			B	alti	more								1 ☑ Yes 2 ☐ No
the	r 28a notif	irec	10e. Street and Nu	ımber			-			10f. Zip	Code				10g.	Citizen of	f What Cour	ntry?
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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 6 2007

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 20, **Physician** Ada J. Beam November 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. Social Securify Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 □ **X**F Min. 84 Director 213**-**30-9857 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No Lutherville Baltimore Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1311 Burleigh Road Funeral 21093 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3X☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Seamstress</u> Women's Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Orlando Τ. Shaulis Myrtle May Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>George E. Beam, Jr.</u> 1739 Crofton Parkway <u>Crofton, Maryland 21114</u> 20b. Place of Disposition (Name of cemetery, crematory of other place)
Dulaney Valley
Memorial Gardens Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-24-2007 Timonium Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on yone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1405 LUGAL Concen disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 □Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be d 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1∐ Yes or Attending Physiclan; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 158 PLG Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 58303 November 20 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Paint)

HAMON J-CHANIES WIN 6104 N-Chanles ST TOWSON MD 71204 1- COTANIES MM

DHMH 17 Rev 1/2001

State Registrar 32 Registrar's Signature

'Nilliam Blunt 07-08 UNK Med

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		4a. Facility Name (if not instituted 3003 Southland Aven	on, give street and n	umber)	4	b. City, Town, or Lo Baltimore				inty of Death			
Funeral		5. Social Security Number un		7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	1		Foreign	place (State or		
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5-0036 Tled within 7 Hygiene. d other than	Con	17. Father's Name (First, Middle				1	8.Mother's Name						
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001	ME	30. Name and address of per		leause of death (Ite	em 23a) aminer 1	I11 Penn Stree	et, Baltimore,	MD 21201					
	Sta	Mary G. Repple MD	(ear) 3	2. Registrar's Signa		A PROPERTY OF THE PROPERTY OF							
Reg			6 2007	GARAGES L		Profit Res							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 007 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** SACHS BORACK NOVEMBER 20 2007 2:45 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1270271926 Months 1 □ M 2 🛛 F 212-22-4554 80 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits iral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐Yes 2 No Director HOWARD LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9080 STEBBING WAY #K 20723 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No WHITE by Specify: Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY STATE OF MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **EDWARD** SACHS SOPHIA FRIEDMAN မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARLENE BORACK / DAUGHTER 9080 STEBBING WAY APT. #K - LAUREL, MD. 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 'Department of H Important: If ite any injury or ot once. 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RADOMER VEREIN 11/21/2007 ROSEDALE, MD 21. Signature of fluneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Errer t/e disease, or com/lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, the it failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician NEUMONIA /Medical le to (or as a consequence of) Examiner mulwho Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) as been signed by the a should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 Tes Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performe 2□No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2×100 Other: Nursing Home 5 Residence 6 Other (Specify) ٥ 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3∐ DOA After this 27. Mapner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

State

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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2 6 2007

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2114

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Nov 20, 2007 10:47P Patricia Joan Clark /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fairfield Nursing Home Crownsville Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ KF Days Hours Min 215-30-4217 June 4, Director WASH DC 73 1934 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Crownsville MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21032 1454 Fairfield Loop Rd USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Josephine Joan Late 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Husband 408 3rd Ave SW, Glen Burnie, MD William Samuel Clark, Jr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2xxCremation 3 ☐ Removal from State Crownsville Vets Cem Nov 29, 2007 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Corensee 22. Name and Address of Facility, P.A. A Cregity M01148 426 Crain Hwy S, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical quence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner sequence of The law requires that the death certificate be executed sician and burial-tran Division or Vital Records, P.O. Box 68760, \overline{x} Due to (or as a consequence of): Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 分 No 24a. Was an certificate has autopsy perform page 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 📆 🗘 lo 1 Inpatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No s after death 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of

Name and address

MIN person who completed cause of death (Item 23a) (Type, Print) 29c. License number

Heghway SW

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08899 State of Maryland / Department of Health and Mental Hygiene Margaret Kellie Cole Certificate of Death Reg. No. 1- For State Registrar

1. Decedent's Name (First, Middle,Last) 2 Date of Death Month Day November 17, 2007 Physician/ 1130 hrs Examine MARGARET KELLIE COLE Med* 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie 7971 Oakwood Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Davs Hours Country) AUG 29. Director 1 M 2 X XF 31 220.88.2268 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State Yes 2 No or 28a-f show GLEN BURNIE 23a or 28a-f show ANNE ARUNDEL MD 10g. Citizen of What Country? death with the Maryland Director 10f. Zip Code 10e. Street and Number 21061 7971 OAKWOOD RD 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. White, etc. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items ? Armed Forces? 1 Never Married 2 XX Married Yes Specify: WHITE 4 Divorced If Yes, Give Year Yes 2 No specify: Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done "natural" δ, 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hou
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nati College (1-4 or 5+) Elementary/Secondary (0-12) OWN HOME HOME MAKER 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) NORMA JEAN BARTON Be BRIAN KEITH HOGAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7971 OAK WOOD RD. GLEN BURNIE MD 21061 HUSBAND JEMALEDDIN SASHA COLE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 11/23/200720a. Method of Disposition crematory or other place) Burial 2 XX Cremation 3 Removal from State BALTIMORE, MD 20071123 BAYVIEW CREMATORY INC Other Specif Donation 5 22 Name and Address of Facility
FINK FUNERAL HOME, P.A.
426 CRAIN HWY SW CLEN BURNIE, MD 21061 Signature of Funeral Service Ace 21 GREGORY KINK M01148 Approximate Interval Κ complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Part I. Enter the disease, or co allure. List only one cause nhysician edical Death Pneumonia Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed events resulting in death) Last and **X** AMENDED #23a,27,perME,g875, #20b Per FH G873 11/ 1/11/08 TI Physician/Medical te attending physician a for use as the burial X UNPENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy Box 68760 Year IF FEMALE Month Day 3 Ectopic pregnancy Fetal death 3b. Was decedent pregnant in the Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown icate has been signed by the att page 2 should be detached for Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 V No 3 Probably 4 Unknown ě 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 certificate 26.Place of Death (Check only one) 25. Was case referred to medical director, Other4 Nursing Home 5 Residence 6 Other: Scene Be examiner? Hospital: DOA ER/Outpatient 3 Inpatient 2 No this 1 V Yes 28d. Describe how injury occurred ပ 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury funeral 27. Manner of Death After Certification: Yes 2 No 1X Natural thin 24 hours after death.

the Funeral Director: Ampletely filled in by the fu Pending 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3 Could not be Suicide determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

State

within 7

NOV 2 6 70 DCME

Donna municonti, mio 30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Donna M. Vincenti, MD

31. Date filed (Month, Day, Year)

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

ORIGINAL

THE !

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 18, 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month November 20 200711:22A Physician Robert Ronald Clark /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GilChrest Hospice Baltimore Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year)
11/26/1931 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** 1**X** M 2□F Days 219-28-0281 75 Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b, County 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 ☐ Yes X☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be so filed within 72 hours after death v Hygiene. kther than "natural", or items 23a 515 Tidewater Lane Funeral 21220 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 (X Yes 2 □ No If Yes, Give Year or Date 5 2 − 5 4 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Exxon Oil Oil 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter H. Clark Catherine Rolf 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Files/Daughter 515 Tidewater Lane Baltimore MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith | 11/24/07 | Baltimore MD 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature of Funeral Service Licenses 1211 Chesaco Ave Baltimore MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** YEARS /Medical Due to (or as a consequence of): Examiner COLONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent e of) Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death signed by the a 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown STROKE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No was ...
autopsy
performed?
Yes 2/2 No page certificate To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Wother (Specify) HDSP(CE Certification: To 1 ☐ Yes 2 No 1 Inpatient After this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: the ! 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

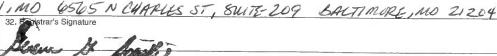
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Registrar

31. Date filed (Month, Day, Year) NOV 26

DANIEUE DOBERMAN, MO

29b. Signature and title of corti



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29d. Date signed (Month, Day, Year)

NOVEMBER 20, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene											
1- For State Certificate of Death Reg. No. 2013 Time of Death											
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Le leste A; Crenshau	C i a l/ Month [oay Year 0722 hrs								
(Facility Name (if not institution, give street and number) Harbor Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death								
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last bit	7/	MM/DD/YYYY) 9. Birthplace (State or Foreign								
Director	159-50-2570 1 M 2 F 51	Yrs. Months Days Hours Min. 08-27-	(956 Country) P7 :								
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ryland a-f sho	10e. Street and Number	10f. Zip Code 10g	. Citizen of What Country?								
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 33a or 28a-f show re other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1106 moneta Ct.	21225	U.S.A.								
rdeath with or items 2: must be m	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.								
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That that		and in the disconjing codes given in	2 No 3 Probably 4 V Unknown								
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of Vital Records, Ing Physician: The law requires the this certificate has been signeral director, page 2 should be not To Re Commisted.		perfor 1 ✓ Yes : 26.Place of Death (Check only one)									
Vital ysician: his certification.	25. Was case referred to medical examiner? Hospital: 1 Innation: 2 FR	Tout	Residence 6 Other:								
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Division Division Hospital or Attend 24 house after death Funeral Director: rely filled in by the f	3 Suicide 6 Could not be determined (Specify)										
Division o To the Hospital or Attending within 24 hours affect death To the Funeral Director: Afte completely filled in by the fune	29a. Certifier 1 Certifying Physician: To the best of my knowledge, one) 2 Medical Examiner: On the basis of examination and/and manner stated.	death occurred at the time, date and place, and due to the caus or investigation, in my opinion, death occurred at the time, date	e(s) and marrier as stated. and place, and due to the cause(s)								
T in its	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) November 23, 2007								
	30. Name and address of person who completed cause of death (Item 23										
Ø [Melissa Brassell, MD Assistant Medical Examiner	111 Penn Street Baltimore MD 21201									
Stat Registra	e 31. Date filed (Month, Day Year) 2007 37 Registrar's Signature	A Service Control of the Control of									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 7

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	or 2	Dire	10e. Street and Numb					10f. Zip				10g. Cit	tizen of Wha	t Country	y?	
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	r deg	Ine	11. Marital Status		12. Was Deced Armed Ford 1 Yes 2	ent Ever in U	J.S. 13.	Was Deced	dent of His	spanic Origin? (Specify Yes or N rto Rican, etc.)	0-	14. Race - /			
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12	vithir ne. han	E G	Elementary/Second	lary (0-12)	College (1-4	4or 5+)	1		se retired)		5					
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Maryland 21215-0036	2 sh and Is m		19a. Informant's Nam James Carr	, ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Iiiahan					Tural Route Numi					
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		20a. Method of Dispos		Bemoval from St	ate 20b. I	Place of Dispo cemetery, crei	sition (Nan natory or o	ne of ther place	e) :	Date	20c. Lo	cation - City	or Towr	n, State	
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	The law requires that the death certificate be executed Wedming the has been signed by the attending physician and age 2 should be detached for use as the buriat-transit		23a. Part1. Enter the shock, or heart f	disease, or of my	plic that cau	used the deat	th. Do not ent	er the mode	e of dying	, such as cardia	ac or respiratory a	arrest,		A	pproximate	
			shock, or heart failure. List only on cause on each line. Immediate Cause (Final disease or condition on resulting in death) _a											ith		
			resulting in death)			as a conseq								100	days	
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<u>.s</u>	or Attending Physician: after death. Director: After this certification by the funeral director,	Certification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of injury: At home, farm, street, factory, office 28f. Location (Street and Number of Factory)													
<u>></u>	or A after Direction by	Ħ	4 Homicide	determined	building	, etc. (Specif	y)	et, ractory,	, опісе		28f. Location (Street an wn, State	d Number or)	Rural R	oute Number,	
1	lo the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 15	A Carrieria- St.	refelent To the t	not of any la										
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	12		30. Name and address													
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	Sta Registr	te	31. Date filed (Worth, I	Day, Year)	32. Hegi	istrar's Signa	ture							I		

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day GEORGIA 4:15 am NOVEMBER 2007 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Medical Baltrune Morre Courter If Under 1 Year If Under 24 Hrs. Months Days Hours Min. May 21, 1940 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🕱 F West Virginia 214 38 1967 Yrs. 67 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2 No Middle River 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 1 Sproul Court 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Yes 2 💆 No Specify White 3 ♥ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Grant Gutshall Elizabeth Anne Cook 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Orlando F. Cellini III (Son) 1 Sproul Ct. Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens Of Faith Cemetery 11/26/2007 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Sign Aure Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Quelo Metrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 tonknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 26. Place of Death (Check only one) Hospital: Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28¢. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury

Physician /Medical Examiner A pue death certificate be executed burial-transit physician sthe burial Box 68760, as nse P.O. Division or Vital Records,

Physician

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

'natural", the Medical

al Hygiene.

Mental and Mental is marked o should be

f Health item 27 i

permit. Pages 1 Department of H Important: If ite any injury or ot once.

Director

Completed by Funeral

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Examiner

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filed within 72 hours after

Baltimore, Maryland 21215-0036

/Medical

Physician/Medical signed by the a d be detached for ð Completed · has page 2 certificate director, Be P this After thi funeral Certification: death. Il Director: / after within 24 hours a

To the Funeral C Medical

or Attending Physician:

To the Hospital

25. Was case referred to medical examiner? 1 Yes 2 No

> 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

29b. Signature and title of certifie

29a. Certifier

5 ☐ Pending investigation 6 ☐ Could not be

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

Mysician

address of person who completed cause of death (Item 23a) (Type, Print)

81.

29c. License number

November 21, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State

0

Registrar

31. Date filed (Month, Day, Year) NOV 2 6 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Clara Grace Clark 9:40 P /Medical November 20, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ivy Hall Geriatric Center Middle River Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/02/1931 9. Birthplace (State or Foreign **Funeral** Months Days Hours 76 212-28-8068 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Venturi Road 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2**X** No þ 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Campoli Julia Ferinni 2 19a. Informant's Name/Relationship (Type. Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21666 Department of Health ar Important: If item 27 is any Injury or other trau 108 Indian Spring Court, Stevensville, Maryland Jacqueline Dawn Zarachowicz 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State MXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem Garden 11/28/2007 | Middle River, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Lichard 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Du no (or as a consequence of): MIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA

Physician /Medical Examiner

the death certificate be executed

Box 68760.

P.O.

Records,

Division or Vital

Physician:

Hospital

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Pages 1 and 2 should

Baltimore, Maryland 21215-0036

and attending physician for use as the buria page 2 funeral director, Certification: To

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Uneral Director: After t After t filled in by within 24 hours a To the Funeral I completely

> State Registrar

DHMH 17 Rev 1/2001

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifi-29d. Date signed (Month, Day, Year)

Year)

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Year 200 2 /Medical Facility Name (If not institution, give street and number) 4b. Cly, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 6. Se If Under 24 Hrs. 8. Date of Birth (Month, Day Year Birthplace (State or Foreign Country) vrs. last birthday **Funeral** Months Days 1 □ M 2 📉 237-60-1070 Director Usual Residence of Deceden and 2 should be filed within 72 hours after death with the Maryland eaith and Mentel Hygiene.

n 27 is marked other than "natural", or items 23a or 28a-f show ne 72 is marked other than "natural", or items 23a or 28a-f show ne traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location ms 23a or 28a-f show must be notified at 10d. Inside City Limits 1 Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code orove Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11 Marital Status Black, White, 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Glai Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) more permit. Pages 1 al Department of Hes Important: If item any injury or othe once, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State timore 21. Signature of Funeral Service Licen Funeral 23a. Part1. Enter the decease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart before. List only one cause on each line. Arproximate Interval Between Onest and Death Immediate Cause (Final disease or condition resulting in death) Physician Zhourd /Medical Due to (or as suence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ NO Day Month Year 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a 9□Unknown tate has been signed lipage 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Inpatient 2 2 ER/Outpatient 3 DOA $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After 5 ☐ Pending investigation 1 Watural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) d manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) e of death 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 6 Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 6:23 a M MICHELLE CAPERS November 16 2007 KAYLA /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD CO 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2(XF Yrs. Director 20 630-07-1822 June 22, 1987 SOUTH CAROLINA Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or items 23a or 28e-f sho other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 XNo MARYLAND HARFORD ABERDEEN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 460 MANOR COURT 21001 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after of dealth and Mental Hygiene.
Im 27 ie marked other then "neturel", or Itel 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) APG/ HARFORD C.C. 12th grade CASHIER/STUDENT lyr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ CLARK CAPERS MARTLYNN CAPERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Clark Capers/Father 460 Manor Court, Aberdeen, Md., 21001 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Depertment of Important: If it eny injury or o cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBRON BAPT CEMETERY | 11-24/07 CLINTON, SOUTH CAROLIN 21. Signature of Funeral Service Licensego 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Derbona Blown 321 S. PHILADELPHIA BLVD, ABERDEEN, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Priysician PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Robable Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MORBID 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? tonsillectom After this certificate funeral director, pag RECENT 1 Yes 2 No 1 X Yes 2 No or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 XYes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours efter death. To the Funerel Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 035012 and November 20, 2007

Registrar

State

501

South Union Ave, Harre DeGrace, Md. 21078

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ms.

Registrar's Signature

J. Kevin LYNCH

NOV 2 6 2007

31. Date filed (Month, Day, Year)

29c. License number 25 3 9 /

29d. Date signed (Month, Day, Year)

within 24 hours after death.

To the Funeral Director: All completely filled in by the fu Hospital

10

State Registrar 29b. Signature and title of certifier

of person who completed cause of death (Item 23a) (Type, Printegral Blvd, Baltsmore MD21239. 32. Registrar's Signature

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 0155 NOV. MARIE CATHERINE CONDON /Medical County of Death BALTIMORE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** TOWSON GILCHRIST CENTER 8. Date of Birth (Month, Day, Year) July 24,1929 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Maryland Months Days Hours 1 □ M 2/17 P 78 **Director** 214~26~4432 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 🛛 No Director Baltimore County Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or Items 23a or USA 21237 5111 King Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify þ XXWidowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County School Bus Matron . Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant: If Item 27 is marked other th jury or other traumatic event, the 6 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise C. Milke James N. Borland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4355 Blue Hill Rd. Hanover, Pa. 17331 Sandra L. Stevens (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. Baltimore, Maryland 11-26-07 Gardens of Faith Cem. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 7401 Belair Rd. 22. Name and Address of Facility Lassahn Funeral Home Laeschn Baltimore, Md. 21236 23a. Part1. Enter the disea of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Bowe Immediate Cause (Final youth5 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of months Examiner Color Sequentially list conditions, if any least of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending nse 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregpant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day Month Year Po in the past 12 mooths? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐Mo P.O. the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 2 Nin 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Fother (Specify) 2 10 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes 2 this funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Hospital or Attending Pl 24 hours after death. Funeral Director: After ti After t Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral C Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 6701 Ni Charles St. Balto md 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 20, 2007 **Physician** 7:35 PMM Alfreda Louise Chesniak /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkridge Howard Angels Alert Assisted Living If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 01/03/1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 M Maryland 90 213-05-6899 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be r 21043 United States 8385 G Montgomery Run Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Draszkiewicz Ludwig Szczesniak ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pormit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau 8385 G Montgomery Run Road Ellicott City, MD 21043 Judy Pasquantonio / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1≥Burial 2 □Cremation 3 □Removal from State Holy Rosary Cemetery 11/24/2007 | Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Light David J. Weber Funeral Homes PA 5311 Edmondson Avenue Baltimore, MD 21229 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 Unknown been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 245. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has e 2 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Assisted 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b Time of : After Certification: (Month, Day Year) 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral D 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KNOLL NONTH Dr. SLITT 260 COLUMBIN 2104 6 31. Date filed (Month, Day, Year) Registrar's Signature State 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Dav Dorothy Ann Crutchfield /Medical November 17, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Stella Maris Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 6 Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Days 1 □ M 2**X** F Hours Director May 14, 216-34-5142 73 1934 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1xxXYes 2 □ No notified Director MD n/a Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or e items 23a c iner must b 6303 Leith Walk 21239 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must by Funeral Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XX If Yes, Give XX Year or Dates: 1 □ Yes 2 XXIo White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mental Health Care Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Crutchfield ည Dorothy Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Pfouts (sister) 9122 Covered Bridge Road Parkville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) .a Crosse Cemetery 11/27/2007 La Crosse, VA 21. Signatu 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. of Fa ral Service Licensee 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RENAL CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-trai Due to (or as a consequence of) Physician/Medical as the Se IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Year 4☐Pregnant at time of death Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 10ther (Specify) Hospital: 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

the Maryland

with

Maryland 21215-0036

Baltimore, NOVEMBER

> and attending physician ed by the a been signed by the should be detach page 2 should has certificate funeral director,

Records, P.O. Box 68760.

Division or Vital

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Certification:

Medical

or Attending Physician: After this within 24 hours after death To the Funeral Director: the 1 filled in by the Hospital

State

Registrar

1 ☐ Yes 2 No 27. Manner of Death

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

one)

1 X Natural 5 ☐ Pending investigation 2 ☐ Accident 3 ☐ Suicide

6 ☐ Could not be

28a Date of Injury

(Month, Day Year)

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28h Time of

28c. Injury at Work? 1 ☐ Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

29d. Date signed (Month, Day, Year)

HOSPICE

TIMONIUM, MD 21093

miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Norma D. Codd 6:50 November 21 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Agnes Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 □ M 2 🔀 F 213-09-4461 92 March 20, 1915 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TX No Maryland Baltimore Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 207 N. Beechwood Avenue 21228 IISA 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 ☐ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Monaghan Dolores Habighurst 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Codd 37 Dunvegan Road; Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) New Cathedral 11/27/2007 Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee Nanda Lemm 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Health associated car priummia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ei7 wu Due to (or as a Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? fibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 7 No 24a Was an 2 No

Physician /Medical Examiner Examiner certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f shov Ħ notified

ns 23a or 2 must be n items 23a

Examiner

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and Mental Hygiene. Is marked other than

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Pages 1 and 2 should be timent of Health and Ments tant: If item 27 Is marked

permit. Pages 1 Department of I-Important: If ite any injury or ot

other i

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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burial-tran attending physician for use as the buria Physician/Medical page 2 s certificate director,

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Completed

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Certification: To

Medical

After

after death Director:

within 24 hours a

To the Funeral L

filled in by

Hospital or Attending

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

1□ Yes 2 No 26. Place of Death (Check only one)

Baltimore

28d. Describe how injury occurred

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No 27. Manner of Death

1 🔀 Inpatient 28a. Date of Injury (Month, Day Year) 5 ☐ Pending Investigation 6 Could not be determined

2 ER/Outpatient 3 DOA 28b. Time of Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

1 X Natural

2☐ Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier Bichhum

31. Date filed (Month, Day, Year)

/inh

54996

21 2007 November

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinh Bichhuong

26

2007

900 S. 32. Pojistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Best

Caton

State Registrar 07-08504

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

William Clay	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No. 2007 271.20											
	Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death											
Physician/ Medical Examiner	Month Day Year 1910 hrs											
	William Clay 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death											
	2503 Violet Avenue #105south Baltimore											
Funeral	5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign unk											
Director	1 XM 2 F 59 Yrs. Months Days Hours Min. July 30, 1948 Country)											
	Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits											
w any	10. County											
fand once.	The paretimete											
the Maryland or 28a-f sh- uffed at once	10e. Street and Number 2503 Violet AVenue 105South 10f. Zip Code 10g. Citizen of What Country? USA											
ith the notifi	11. Marital Status UNK 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-											
r death with or death with can see that the no can see the note that the no can see th	1 Never Married 2 Married Armed Forces? unk If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.											
her de	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 X No specify: Specify: black											
ours aft atural" amine	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 11											
5 72 hc ral E.	Elementary/Secondary (0-12) College (1-4 or 5+)											
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan	unk unk											
Hygin the ch	17. Father's Name (First, Middle, Last) UNK 18.Mother's Name (First, Middle, Maiden Surname) unk											
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
MD 7	O.C.M.E. 111 Penn Street Baltimore, MD 21201											
e, N I and Health Health Item	20a. Method of Disposition											
Baltimore, permit, Pages 1 ar Department of Hee Important: If Ite	1 Burial 2 Cremation 3 Removal from State crematory or other place)											
altin nit. P aartme oortar nry or	4 Donation 5 Other Specify: in state											
Balt permit. Depart Import injury	IMALTIMOTE, MI) /1/UI											
Physician	23a. Part I. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart biliume. List only one cause on each line. Approximate Interval Between Onset and											
/Medical	Immediate Cause (Final disease a. Hypertensive atherosclerotic cardiovascular disease Death											
1	or condition resulting in death) Due to (or as a consequence of):											
- a	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
led nsit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c.											
Exa	events resulting in death) Last Due to (or as a consequence of):											
to be executed ysician and burial - transit	▼ UNPENDED											
60, ate be hysicia fedi	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery											
Division of Vital Records, P.O. Box 6876i tal or Attending Physician: The law requires that the death certificate its after death. 31 Director: After this certificate has been signed by the attending phyled in by the funeral director, page 2 should be detached for use as the I ertification: To Be Completed by Physician/IM.	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year											
OX (ox ath ce attence or use or use sici	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown											
the de ched f	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?											
P.C s that gned b e deta	Diabetes mellitus 1 Yes 2 No 3 Probably 4 V Unknown											
Records, The law require. Fricate has been signage 2 should be Completed	24a. Was an 24b. Were autopsy findings available											
COr law r has b e 2 sh mple	autopsy prior to completion of cause of performed? death?											
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ital sician s certi irector	examiner? Hospital: Innation: 2 EP/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene											
of Vi	1 ✓ Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred											
on conding ath.	1 X Natural 5 Pending (Month, Day,Year) 1 Yes 2 No											
Division o spital or Attending tours after death. neral Director: After filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)											
Divis Hospital or / 24 hours after Funeral Dire stely filled in t	Suicide 6 Could not be determined (Specify)											
Di Hospital 24 hours : Funeral etely filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the IMMedical Certification: To Be Completed by Physician/IM	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
Z Z	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)											
	O.C.M.E. November 2, 2007											
	30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
State Registrar	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0											

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Charles D. Cook	4	State of Maryland / Department of Health and Mental H		20	07 371.3								
	R	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Deat	eg. No.	3. Time of Death								
Physician Medical Examine	4		Month November	Day Year 6, 2007	0601 hrs								
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₹ ⁶ +		Union Memorial Hospital Baltimore											
Funeral	5	5. Social Security Number un 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hi		th (MM/DD/YYYY) 9. E	Sirthplace (State or Foreign Country) unk								
Director		1X M 2 F 41 Yrs. Months Days Hours Mi	May 14	, 1966									
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laryla 28a-f	Director	10e. Street and Number 10f. Zip Code 21218	1	0g. Citizen of What Co USA									
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		30. Name and address of person who completed beuse of death (Item 23a)	more MD 241	201									
		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltin	TIOLE, IVID 212										
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Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. la	ast birthday)	If Under		If Under		8. Date of Birt	th(MM/DD/YYY	Y) 9. Birt Foreig	hplace (State or	
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Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	r complications that cor each line.	caused t	the death	. Do not enter th	e mode of	dying, s	uch as ca	rdiac or	respiratory arre	est, shock, or h	eart	Approximate Interval Between Onset and	
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of Vital ng Physician: ther this certi	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatier	nt 2	ER/Outpatient	3 DO	DA C	Other 4	Nursing	Home 5	Residence 6	✓ Othe	r: Scene	
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		Date . (-	2	001) 8		O.C.N	1.E.			Novembe	r 21, 2	007	
	30. Name and address of person who completed cause of death (Item 23a)														
0		Patricia Arpnica-Polla	k MD. Assis	stant M	edical l	Examiner	111 Pe	nn Str	eet, Bal	ltimpre	e, MD 2120	1			
	ate	31. Date filed (Month Day, Year)	6 2007 32.	Registrar	's Signatu	A And	ALL								
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 20, 2007 **Physician** 1:25A PHILIP WYNNE DAVIES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Presbyterian Home of Maryland Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days, Year) | Min. | March 18,1915 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Director 066-09-0178 92 Wisconsin Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notified at 1 □Yes 2 □No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? nit. Pages 1 and 2 should be filed within 72 hours after death with t artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 2 lnjury or other traumatic event, the Medical Examiner must be n 400 Georgia Court 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIV If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2**X**No Specify. <u>ک</u> Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Professor University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howell David Davies Julia Hosford Merrell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margery Wynne Davies DTR 35 William Street Cambridge Mass.02139 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or GreenMount Crematory | 11/23/07 Baltimore, Maryland ☐Donation 5 ☐ Other (Specify) ignature of Funeral Se oce 1 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 23a. Part1. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Althe he s **Physician** Scars /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and certificate be executed burial-transi Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No has e 2 certificate 1□ Yes 225 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🕱 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 🗌 Yes 2 □ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, Division or Vital Records, P.O. after death | Director; | d in by the | 0 To the Hospital o within 24 hours aft To the Funeral Di completely filled in

29a, Certifier 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D370/6

29d. Date signed (Month, Day, Year)
Nove Ser 21, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eath (Item 23a) (Type, Print) 670 l N. Charles St., Sute 4105 Britismon, my 2/204 (reen 200

State Registrar

Medical

2. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 2 6 2007

Attending

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	/Medic	al -	4a. Facility Name (If not in:	stitution give			7 0	4b. City, 7	own, or l	ocation		OVEMB			2 OO7		. W A CO.
	Examin	er	The Johns						LTI					,			
1 de 1	Funeral Director		5. Social Security Number 574–24–8534	6. Se		ge (In yrs. I	ast birthday, 6 Yrs.) If Under Months	1 Year Days	If Under Hours	24 Hrs. 8. Min.	Date of Bi (Month, Date 2)	rth ay, Year 3 , 1	951	Cox	place (Stantry) tana	ate or Foreign
	and ww		Usual Residence of Deceded 10a. State 10b. 0	lent County		10c. City	, Town or L	ocation								10d. Insid	e City Limits
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ Di		12. Was Deceden Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates	? No		1□Yes 2	X No	Specify		y Yes or No an, etc.)	0-	Bla	ce - Amer ck, White ^{y:} Whi		٦,
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Maryland	shoul nd M marl	Ė	19a. Informant's Name/Re	elationship (7	ype. Print)		19b. Mail	ing Address	(Street al	nd Numb	er or Rural F	loute Numl	ber, City	or Town	, State, Z	ip Code)	
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/ita	clan: ertific	Be	25. Was case referred to examiner?	medical	Hoopitali				Oah		e of Death (0						
or /	Physi this o	으	1 ☐ Yes 2 No 27. Manner of Death		Hospital: 129npa		ER/Outpatie	ent 3 DO		4 🗆 N	lursing Home					cify)	
no	ding Phys	ion:	Natural 5 □	Pending investigation	28a. Date of In (Month, E	Day Year)	Injury	M Z	Bc. Injury Work′ 1 □ Y	ai ? ∕es 2 [d. Describe	now inj	ury occu	rrea		
Division or Vital	Attendeath death ctor:	Certification:	0 - 0 - 0 - 0 - 0	Could not be determined	28e. Place of it	njury - At ho	me, farm, s					. Location	(Street a	and Num	ber or Ru	ral Route	Number,
5	al or / after I Dire d in b	erti	4 ☐ Homicide	determined	building,	etc. (Specify	V)					City or To	own, Sta	te)			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C			ysiclan: To the bes niner: On the basis and manner:	of examina											ıse(s)
_	To th within To th comp	Me	29b. Signature and title of	certifier	0			29c	. License					_		, Day, Ye	
			1	Dess.	> MD	>			RES	5 0	00		NU	VEMB	SER	22	2007
	20		30. Name and address of	person who	MD The Jo	inns Hop	icins flo	spital 6	00 NO	orth h	ucife stre	et, Bat	Himon	e, MD	212	87	
	Sta		31. Date filed (Month, Day	, Year)	32. Regis	strar's Signa	ture	well I									
	Regist	ar	NOV S	6 200	A BOOK AND AND AND AND AND AND AND AND AND AND	and shape	1	NEVO/									

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show must be notified at

23a or

or,

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permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If Item 27 is marked other the any Injury or other traumatic event, the once.

Director

Funeral

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Completed

Be ပ္

with the Maryland

within 72 hours after

Baltimore, Maryland 21215-0036

NOVEMBER 20, 2007

ours after death.

Division or Vital Records, P.O. Box 68760

the Hospital or Attending Physician:

within 24 hours a To the Funeral L

MABEL DILWORTH

Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of High that initiated events	b	
	resulting in death) Last	Due to (or as a consequence of):	
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	
ed by Pł	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. D
Complet			24a. V
Be (25. Was case referred to medical examiner?	26. Place of Dea	ath (Check or
70	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	dome 5□F
ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Descr
Certification:	3 ☐ Suicide 6 ☐ Could not be determined		28f. Locatio City or

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s 2 No

ilv one) be how injury occurred

lesidence 6XOther (Specify) HOSPICE

on (Street and Number or Rural Route Number, Town, State)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year)

State Registrar

10

Medical

29a. Certifier

NOV 2 6

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Alicia Diaz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) June 18,1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1□ M 2□ F Puerto Rico Director 216-42-4844 84 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 □Yes 2 No Maryland | Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2030 Knotty Pine Drive Funeral 21009 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2□No Specify:Puerto Rican ģ Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home and Mental Hygie injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Arriada Ana Rivera 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other trau Ann A. Ca<u>napp / Daughter</u> <u>2030 Knotty Pine Drive Abingdon, Md. 21009</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/26/07 Parkville, Maryland Moreland Mem. Park 21. Signature of Funery Sovice Livensee 22. Name and Address of Facility 1050 York Road a Ruck Towson Funeral Home, Inc.Towson.Md.21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last monia Examiner ue to (or as a consequence of): Cardiac acrest Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perforr certificate 1∐ Yes the Hospital or Attending Physician; 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 200 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

Division or Vital Diaz, To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi

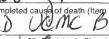
P.0.

Records,

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



29c. License number

29d. Date signed (Month, Day, Year)

NOVEMBER 20, 2007

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATRICIA GURM, AD COME BEL HIR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			1 - For Stata Registrar	State of Ma		ertificate of D			2007	37437
	Physic /Medi		1. Decedent's Name (First, Middle, Lucille Dicken	s				2. Date of Death Month November	Day Year 14, 2007	3. Time of Death 10:48 PM
20	Exami	ner	4a. Facility Name (If not institution, Future Care Ch 5. Social Security Number	arles Villa	ge a (In yrs. last birthday	4b. City, Town, or Lo		8 Date of Birth	4c. County of Dea	
	Funeral Director		219-10-7206 Usual Residence of Decedent	1□M 2∏F	82 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Oay, Y Sept 23,	1925 Nor	thplace (State or Foreign ountry) th Carolina
	hours after death with the Maryland lural', or Itams 23a or 28a-1 show Executive roust be redified at	Director	MD 10a. State 10b. County MD 10e. Street and Number		10c. City, Town or L Balt	imore 10f. Zip Code		100	0	10d. Inside City Limits 1√2 Yes 2 □ No
	death with	Funeral Di	2700 N. Charles	12. Was Decedent 8	Ever in U.S. 13.	212 Was Decedent of Hisp If Yes, specify Cuban,			USA 14. Race - Ame	erican Indian,
0036	72 hours after "natural", or Ita	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:	o	1 ☐ Yes 2X No	Specify:			lack
21215-0036	f within 72 jiene. r than "nai	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) unk	Education grade completed) College (1-4or 5- unk	(Give	edent's Usual Occupation of work done durn DO NOT use retired) domestic	ring most of work	ing	b. Kind of Business	Industry unk
yland 2	be de de de	To Be C	17. Father's Name (First, Middle, La Arthur Dickens				8. Mother's Name	e (First, Middle, Ma	iden Sumame)	
e, mary	1 and 1ealth Im 27 thar to		19a. Informant's Name/Relationship Bertha Culbreth, 20a. Method of Disposition			E. Lafayet	tte Stre	et Baltin	nore, MD 2	21203
baltimore	t. Page rtment c rtant: If		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☒ Other (Spe	city) in state	cemetery, cre	matory or other place)	1		c. Location - City or	
ñ	permi Depa Impo any ii		21. Si nature of Euneral Service Lic RON 21. S 25a. Part 1. Enter the disease, or or shock, or heart failure. List or	emplications that caused	the death. Do not en	2. Name and Address of tate Anatom altimore, M ter the mode of dying, s	$m_{}2120$	1		Approximate Interval Between
	Pny sicia n /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	aend		ular	ent	ia		Onset and Death
		niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):	ular	dise	ase		years
0/00,	cate be executed obysician and the burial-transit	dical Examin	that initiated events 'resulting in death) Last	c	consequence of):					
.O. DOX 0	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year
ב, כם	w requires that been signed is should be det		Part II. Other significant conditions Chronic (M	dray di	not resulting in the u	nderlying cause given in	n Part I.	23e. Did tobac	co use contribute to	the cause of death?
		Completed by	rascular dis	iease,	stage	4'left		24a. Was an autopsy performed	24b. Were au prior to death?	ntopsy findings available completion of cause of
SIOII OI AIR	To the Hospital or Attanding Physician: The law within 24 hours after death, within 24 hours after death. Of the Funarial Diractor: After this certificate has completely filled in by the funeral director, page 2.	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigate Accident 3 Suicide 6 Could not	be	Year) 28b. Time o	nt 3 DOA Other f 28c. Injury at Work? M 1 Yes	4 Nursing Hor	28d. Describe how i		
2	To the Hospital or Attandi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu		4 Homicide determine			,		City or Town, S		
	to the Hospital within 24 hours a To the Funaral I completely filled	Medical	(Check only one) 2 Medical Expone) 29b. Signature and title of portifier	aminer: On the basis of e	examination and/or in	vestigation, in my opinio	on, death occurre	ed at the time, date	e(s) and manner as and place, and due Date signed (Mont!	to the cause(s)
			30. Name and address of person who	o completed cause of dea	ath (Item 23a) (Type,	Print))4195	14.	11/16/07	21218
	Star Registra	_	Lebelcatin V 31. Date filed (Month, Day, Year) NOV 2 6	2007 2700 32. Registrar	's Signature	harles	TBa	Ulmor	em)	01218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 16, 2007 9:25 AM November /Medical Dorothea B. Duerling 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Oakcrest Village Health Center 5. Social Security Number | 6. Sex | 7. Age (In vrs. le. Parkville If Under 1 Year If Under 24 Hrs. Baltimore Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🔽 F 86 Vrs Mar 27, 1921 Maryland Director 217**-**14-0663 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show natural", or items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA 8832 Walther Blvd Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔯 No 3altimore, Maryland 21215-0036 Specify: white ģ 3 ☐ Widowed 4 ☐ Divorced unk Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Schriber McGregor Walter Wells Beigel other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health au Important; If item 27 is any injury or other trau 163 William Street Bel Air, MD 21014 David Duerling/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) S's atur of Funeral Dervice Licensee Romald S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Late Stage Dementia **Physician** /Medical Due to (or as a consequence of) Examiner Parkinsons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine physician and the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No

Mrs. Duerling, Dorother Division or Vital Records, P.O. Box 68760, within 24 hours after

To the Funeral Direct

completely filled in by

Completed by Be Medical Certification: To

26. Place of Death (Check only one)

28d. Describe how injury occurred

25. Was case referred to medical 1 ☐ Yes 2 No 27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year)

and manner stated.

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

29c. License number H 5 2 365 29d. Date signed (Month, Day, Year) November 16, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8832 Walther Boulevard, Parkille Maryland 21234 Jeffreys, D.O.

State Registrar

31. Date filed (Month, Day, Year) NOV 2 6 2007 37 Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year John 730AM 11 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FRANKLIN Baltimore Square HOSPITAL CENTER Rosedale If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Yrs. 9. Birthplace (State or Foreign Country) **Funeral** 212 22 56 8 1**Ã**M 2□F Months **Director** Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show at 3a or 28a-f sh Funeral Director BAltiMOTE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a (must b 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 □ No 9 5 ⊚ If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married ٥, If Yes, Give Year or Dates: 1 ☐ Yes 2 No ģ Specify: 3 Widowed 4 □ Divorced 1952 Completed permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur any Injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STEEL 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be DOUG GAS 2 19a. Informant's Name/Relationship (Type. Print) DAUE h LER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAULETTE OOVELA altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 28/07 0Wings M.11 4 ☐ Donation 5 ☐ Other (Specify) CVI 21. Signature of Funeral Service Licens 22. Name and Address of Facility Phillip A WEATHER FORD FS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transi and Due to (or as a consequence of): physician Physician/Medical as the signed by the attending d be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 24a. Was an autopsy certificate 1□ Yes a No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) No No Certification: To 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760, Division or Vital Records,

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

Registrar

Year)

NOV26

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Name and address of person who completed cause of death (Item 23a) (Type, Print) Woods Road Switch 3h, MD 21231

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

			1 - For Amend 9,15,1	State of 6a-b,17,18, p	Maryland erFH,G87	d / Depa 3, 11/20	ortment of F	lealth a Death	and Men	ntal Hyg	iene 2 ()	07	37440
	Physic /Medi		Decedent's Name (First, Middle Harrison Davis	e, Last)						Date of Death Month		Year	3. Time of Death
	Examir	ier	4a. Facility Name (If not institution THI — MD at Liberty	n, give street and num Heights, LLC	ber)		4b. City, Town, o	r Location o Balti	of Death More		4c. County o		
	Funeral Director		5. Social Security Number 251–32–0278	6. Sex 7 1 ½ M 2 ☐ F	'. Age (In yrs. la 7	as <i>t birthd</i> ay) 8 Yrs.	If Under 1 Year Months Days	Hours	Min.	Date of Birth (Month, Day, rch 15,	rear)	9. Birthpl Count	ace (State or Foreign ry) 1mk
	/aryland f show ed at	or	Usual Residence of Decedent 10a. State 10b. County MD		10c. City	, Town or Lo	cation	Baltim	ore			10	od. Inside City Limits
	with the N a or 28a-	Direct	10e. Street and Number 4017 Liberty Height	s Avenue			10f. Zip Code 2120	 07		10	g. Citizen of WI	nat Count	
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 🛣 Widowed 4 □ Divorced	12. Was Deced	es? 控No		Vas Decedent of H f Yes, specify Cuba		gin? (Specify , Puerto Rica	Yes or No- an, etc.)	14. Race Black	- America , White, e Afri . Amer	tc. .can
21215-0036	be filed within 72 hours after death with the Marylan ntal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12) 12	's Education		16a. Deced (Give life. D	ent's Usual Occup kind of work done of OO NOT use retired	ation during most during most	t of working		 6b. Kind of Bus Car deale		ustry unk
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	nd 2 sh alth and 27 is m r traum		19a. Informant's Name/Relations Cassandra Lucas / G	,			g Address <i>(Street a</i> Calvert St						Code)
	Pages 1 a ment of Hes ant: If item ury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ce ce	metery, crem	sition (Name of natory or other place Cemetery	ce) 1	Date 11/24/20		oc. Location - Caltimore,	-	
Dair	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service	Licensee	,	22.	Name and Addres				al Home, I ce, Maryla		1217
	Physician /Medical Examiner	Ø. 0	23a. Fart1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	a	used the death. ch line.	rope	er the mode of dyin	g, such as c	cardiac or res	spiratory arre	st,		Approximate Interval Between Onset and Death
,0070	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uissass or injury that initiated events resulting in death) Last	с	as a conseque								
.O. DOX 0	or the respital or Attending Prysician; The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ☐ Fetal on that time of dea	death 3 🗌	Ectopic pregnancy Other <i>(specify)</i>				23d. Date Mont		y Day Year
COLUS, T	equires that an signed build be deta	ρ	Part II. Other significant condition		th but not result	ting in the und	derlying cause give	en in Part I.		23e. Did toba 1 ∐ Yes		ute to the	cause of death?
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1	in 24 hou	Medical	29a. Certifier 1 Certifyin (Check only one)	Physician: To the be examiner: On the base and manage	is of examination r stated.	on and/or inve	estigation, in my op	pinion, deatl	h occurred at	t the time, da	te and place, an	d due to t	ted. he cause(s)
)	with To	2	29b. Signature and title of certifier	angle construction and a second			29c. License PAN MON	number TOH	14	290	d. Date signed (Month, D	ay, Year)
3			30. Name and address of person of	who completed cause	of death (Item 2	23a) (Type, P	rint)	OIR	eny 1	Pel	2121	7	
er	Sta Registra		31. Date filed (Month, Day, Year)	92. Reg	istrar's Signatu	re	E)	-					

			, roi	partment of Health and Mertificate of Death	ental Hygier	2001	37441
	Physicia		1. Decedent's Name (First, Middle, Last) Hazel Eleanor Ellis		2. Date of Death Month	Day / O Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	117	4c. County of Death	
ı		٠	Carroll Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Westminster // If Under 1 Year If Under 24 Hrs.	R Date of Birth	Carro	
	Funeral Director		230-30-8962 1 M 2 T R 80 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Aug 16,	1927	place (State or Foreign ntry) VA
	pur &		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or in the county	ocation			10d. Inside City Limits
	Maryla	ō	MD Carroll	Sykesville			1 ☐ Yes 2 ☐XNo
	or 28a-	irec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	ath wit	raiD	4 Bethway Drve Apt. 103	21784		USA	
220	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menlail Hyglene. Important: If lien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Manical Examinar or other traumatic event, it is Manical Examinar or other traumatic event, it is Manical Examinar or other contribution at once.	by Funeral Director	11. Marital Status 1. Marital Status 1. Marital Status 1. Was Decedent Ever in U.S. Armed Forces? 1. □ Yes 2. □ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☐ No Specify:	city Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: W	
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Ma	d 2 sh th and th and 7 ls m traum			ling Address <i>(Street and Number or Rural</i> ethway Dr. #103 Syl	Route Number, Cit ${\sf kesville}$,		p Code)
ש	s 1 and f Health item 27 other tr		20a. Method of Disposition 20b. Place of Disposition			. Location - City or T	own, State
	Pages ment of P ant: If its ury or of			Mem. Gard. 11/26	/2007 Mari	tiottsville,	MD
מפו	permit. Departr Importe any inju		21. Signature of Funeral Service Licensee Buan L Hault Mooney S	A TUHTO FUNERATONHOME Sykesville, MD 21784	& CHAPEL 4 (410)-	P.A. (B 795-1400	ox 195)
			23a. Part1. Enter the disease, or complications that aused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death
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	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
6	yned by	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
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שו חמכ	: The law cate has b page 2 st	Completed	'/		24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of
<u> </u>	siciar s certif	o Be	25. Was case reterred to medical examiner? 1 ☐ Yes 2 M No Hospital: 1 ☐ Inpatient 2 MER/Outpatient	26. Place of Death ont 3 DOA Other: 4 Nursing Hom	(Check only one) ne 5 ☐ Residence	6 □Other (Spec	ifv)
5	ng Phy ter this neral c	-	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury		8d. Describe how in		-77
200	itendir Jeath. tor: Af the fu	ertification;	2 Accident investigation	M 1 Yes 2 No	Bf. Location (Street	and Number or Ru	ral Poute Number
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal of the best of examination and/or and manner stated.				
	To th within To th compl	Me	29b. Signature and title of gentifier	29c. License number	29d. I	Date signed (Month	Day, Year)
	2		· hete yu mo	10058137	7 (1/23/07	7
	9		30. Name and address of person who completed cause of death (Item 23a) (Type Wilbert Kuo 295 Stone Ave		ister 1	MO 211	57
	Sta Registra		31. Date filed (Month, Day, Year) NOV 2 6 2007 Stewart Free Ave	park			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** LEORA REDERICK November 21 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALT MORE RANDAUSTONN NIRITIOES/ Coston USSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 24, Year 20 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Pennsylvania 176-16-0883 1 □ M 2 👿 F 87 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes XX No Maryland Baltimore Gwynn Oak Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States of America 21207 6825 Campfield Road, APT 1 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: White 1 □ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Radio Elementary/Secondary (0-12) College (1-4or 5+) Broadcasting Radio Traffic Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Caroline K. Gehring Charles C. Wagner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: if item 27 is any Injury or other trau (Spouse) 6825 Campfield Road, APT.1, Gwynn Oak, Maryland 21207 Mr. John O. Frederick 20c. Location - City or Town, State 21784 Method of Disposition

↑ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 3 □Removal from State Lake View Memorial PK 11/26/07 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility oring Byers Funeral Directors, Inc 21. Signature of Functial Service 8728 Liberty Road, Randallstownm Maryland 21133 mou 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PU(MONARY **Physician** SEVENE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, for cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last physician and the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Year Month in the past 12 mopt Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Whiknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? Yes 2 No 1□ Yes certificate FAILURE Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Department 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident reral Director: / 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CENTUAN new ORLANDO. B

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month

strar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 22, 2007 5:00 A M November Filler Florence Lillian 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) N/A Baltimore Fort Haven Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Yea April 25, 19 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months 1 □ M 2 🔀 F 91 171-01-1262 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐No Dundalk Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 USA 510 Brandyvale Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Yes No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmetology Hairdresser 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna K. Bectloff Thomas Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 510 Brandyvale Way, Dundalk, MAryland 21222 Daughter Janet Filler 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November November 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Glen Burnie, MD. 26, 2007 4 Donation →5 Other (Specify) 21. Signature Juneral Service Licencee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) THEROSCHEROTIC Discots EREBRO Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Driknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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27 : If item 27 or other t

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

burial-transit and physician the þ this After t 24 hours after death.

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

Examine Physician/Medical Completed by Be

25. Was case referred to medical examiner? Certification: To 27. Manner of Death

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

1 Yes 2 No

Natural

29a. Certifier

24a. Was an autopsy performed 1 Yes 2 □

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 21Mo

(Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

				20	o. Place of Dea	atti (C)	neck only one)	
Н	ospital: 1 ☐ Inpatient 2	ER/Outpatient	3 🗆 🛭	OOA Other:	4 Nursing H	lome	5 Residence	6 ☐Other
	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 □ No	28d.	Describe how inj	ury occurred

5 Pending investigation 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

rani mn) reem 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 HVE SUITE 23 Registrar's Signature

State Registrar

within 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200^{Year} CLAIRE NOVEMBER 19 11:55 P™ FOX 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SUNRISE OF COLUMBIA HOWARD COLUMBIA If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) NY Days Months 1 □ M 2 🕶 F 01706/1920 87 086-12-0962 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 21044 U.S.A. 6500 FREETOWN ROAD SUITE 207 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 No If Xes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **EDUCATION** TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SCHMER RUBIN PAULINE Н 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11089 WINEGLASS COURT - COLUMBIA, MD 21044 LAWRENCE FOX / SON 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State STAR OF DAVID 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/23/2007 NORTH LAUDERDALE, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

attending physician for use as the buria signed by the a has funeral

law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	23a. Part V. Enter the disease, or composite shock, or neart failure. List only of	plications that caused the death. Do not enter the one cause on each line.	mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	PNEUM				Onset and Death
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Examiner	if any, leading to immediate cause (Disease or injury that initiated events				(1)	
	resulting in death) Last	Due to (or as a consequence of):				
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ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ecto 4 □ Pregnant at time of death 5 □ Othe 9 □ Unknown	pic pregnancy er (specify)		23d. Date of deli Month	very Day Year
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E 0				autopsy performed? 1□ Yes 2□No	prior to death?	ompletion of cause of
e a	25. Was case referred to medical examiner?		26. Place of Death (Check only one)		
0	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Vursing Home	e 5 🗆 Residence	6 ☐Other (Spec	cify)
cation:	27. Manner of De h 1 Natural 5 Pending investigation		28c. Injury at 28 Work?	d. Describe how inju	ry occurred	
Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	ctory, office 28	f. Location (Street as City or Town, State		ral Route Number,
edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Example 1	ysician: To the best of my knowledge, death occular: On the basis of examination and/or investigand manner stated.	rred at the time, date and place, ar ation, in my opinion, death occurred	nd due to the cause(s d at the time, date an	s) and manner as ad place, and due	stated. to the cause(s)
Ĕ	29b. Signature and title of certifier		29c. License number	29d. Da	ate signed (Month	Day Year)

DO052861

VALI / 12640 CLARKSVILLE PIKE - CLARKSVILLE, MD 21029

Registrar DHMH 17 Rev 1/2001

State

within 24 hours after death

To the Funeral Director:
completely filled in by the filled in by the

To the Hospital

io

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

AHZA 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician ORIS JAVIN November /Medical City, Town, or Location of Death County of Deal 4a. Facility Name (If not institution, give street and number) Examiner BURNIE top 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/21/1945 Birthplace (State or Foreign Country) Social Security Number Age (In vrs. last birthday **Funeral** Days 1 □ M 2 🗹 F MD 62 Director 219-40-8254 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Funeral Director MD Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 U.S.A. 717 207th Street 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 **2** If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: Be Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Private Daycare 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Orf Charles Wheeler ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207th Street, Pasadena, MD 21122 George D. Gavin / Husband 717 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Pk 11/28/07 Baltimore, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 21. Signature of Emeral Service bicensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 hours **Physician** Myocar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient Medical Certification: To this 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide n 24 hours after der ne Funeral Directo pletely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier TU M November harles 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washing ton Medical Center 301 32. gistrar's Signature 31. Date filed (Month, Day, Year)

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State

Registrar

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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** SAMUEL Α. /Medical GILLIAM November 22 2007 4:48 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD CO If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2 □ F Director 228-30-1580 78 JULY 5 1929 NORTH CAROLINA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes XIXNo Director HARFORD ABERDEEN MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or ? idical Examiner must be n Funeral 640 ELM STREET U.S.A.

14. Race - American Indian, 21001 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 □ Yes 2XXIVo Specify. þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) RETIRED SERVICE OFFICER 12th grade MILITARY or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 JOHN T. GILLIAM MATTIE GILLIAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra Delores C. Gilliam/Wife P.O. Box 241, Aberdeen, Md., 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 □Cremation 3 □Removal from State 4 Donation 5 Dother (Specify) DINWIDDLE MEM. PARK 12/01/2007 PETERSBURG, VIRGINIA 21. Signature of Funeral Service Licens 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Wellena Drown 321 S. PHILA. BLVD., ABERDEEN, MD. 21001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Gilliam Samue M 8004 83065 Division or Vital Records, P.O. Box 68760, 2 attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy ormeu: 2 No 1□ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ို 1 Ampatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0059855 MD 6X1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pper Chesapeake Dr. Belair MD21014 5000 State Registrar

		1	For State	State	of Maryland	d / Depa	ertment of He etificate of D	ealth and M eath	ental Hyg	iene g. No. 2	007	37448
			Registrar Decedent's Name (First, Middle						2. Date of Deat Month		Year	3. Time of Death
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Fun	eral	5	5. Social Security Number	6. Sex	7. Age (III yrs. I		If Under 1 Xear Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Sep. 1	Year)	9. Birth	place (State or Foreign ntry) MD
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In y fail of 2 12 13 2000 should be filed within 72 hours after death with the Maryland and Mental Hygiene. In a Mental Hygiene.	natic	ဥ	19a. Informant's Name/Relation		.2, 51.	19b. Mai	ing Address (Street a			er, City or T	own, State, Z	ip Code)
Mand Strang	traum		Mr. Richard Ga		other)		3 Oskaloos					
Healing Heal	ther		20a. Method of Disposition		20b.	Place of Disp	osition (Name of ematory or other place	e)	Date	20c. Loca	tion - City or	Town, State
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.	injur e.		21. Signatur of Funeral Service				22. Name and Addres			T. PA	(Box	195)
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/Me	dical		resulting in death)	Due	to (or as a conse	quence of):			000			ZWEFCS
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Records, P.O. Box 68 The law requires that the death certifica	nding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,	outcome pf preg ve birth 2 □ Fe	nancy tal death	3 ∐Ectopic pregnanc	v		23	3d. Date of de Month	livery Day Year
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Benjamin David Herron

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 37449

		1- For State Registrar				Ce	rtificate (of De	eath					Reg. No	o		
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Europe		5. Social Security I	Number	6. Sex		7. Age (In yrs.	last birthday)	If	Under 1	Year	If Under :	24Hrs.	8. Date of I	Birth(MN	//DD/YYYY)	g. Birth	place (State or
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or 2	Director		BROWN A	VE.					26	250					USA		
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ision of Vital Records, P.O. Box 68760, thending Physician: The law requires that the death certificate be executed releath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial- transit	ä	UNPENDED		¬ a	MENDED							-	_				
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		thin 24 the Fu	Medic	one) 2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
MD D33910 1000 23, 2007		F 3 F 3		MD D53910 NOV 23, 2007	
36 Name and address of person who completed cause of death (Item 23a) (Type, Print) ANURAL MAHESHWARI NORTHWEST MOSPITAL RANDALLSTOWN MD		10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
State Registrar NOV 2 6 2007				31. Date filed (Month, Day, Year) 32. Registrar's Signature	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 10:30AM **Physician** 007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) tvenue tome wood baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 231-01-455 1 ☐ M 2 💢 F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director timore 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "ne any injury or other traumatic event, the Medis once. Elementary Secondary (0-12) College (1-4or 5+) stodian 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle. Be 2 City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, Informant's Name/Relationship (Type, Print) Ronald C. Harper tomewood **O**a 20b. Place of Disposition (Name of 20a. Method of Disposition Burial 2 □ Cremation 3 □ F 3 Removal from State Baltimore, MD 07 21. Signature of Funeral Service Licensee Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EMBOLISM PULMONARY **Physician** MASSIVE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Day Month Year for 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? /es 2 No certificate 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) 2 No Hospital: 2 ER/Outpatient 3 DOA ٩ 1 ☐ Yes 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 27. Many fer of Death 28c. Injury at Work? Certification: 1 Matural 5 Pending investigation Japital o. 4 hours after dea. •ral Director: A* 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie NOVEMBER 21, 2007 auseare D16619 MD Curr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9940 FRANKLIN SQUARE DR. BALTI HORE, MD. 21236 C.VERGARA-SOARES 32. Hogistrar's Signatur 31. Date filed (Month, State Registrar

07-08993

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Isey Marie Hoc		State of Maryland / Depo	artment of l ertificate of l	Health and Mo <i>Death</i>	ental Hyg	jierre Reg. N	o. 2	007 271
Physician/	_	nistrar Decedent's Name (First, Middle,Last)			2	. Date of Death Month Day	/ Year	9. Time of Death 0708 hrs
dical Examiner	r	Lyndsey Marie Hockett				Month Day November 21	, 2007 4c. County of E	
	48	. Facility Name (if not institution, give street and number)	41	b. City, Town, or Locat Marriottsville	tion of Death		Carroll	Jean I
		1913 Fluse Drive	. last birthday)		Under 24Hrs.	8. Date of Birth(M	M/DD/YYYY)). Birthplace (State or
Funeral Director		Social Security Number 6. Sex 7. Age (In yrs. 14-23-7886 1 M 2 1 F 23	Yrs.		lours Min.	June 23		Country) MD
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withi withingiene.	틹	7. Father's Name (First, Middle, Last)				(First, Middle, Mai		
sal Hy ed of the other	Be	James Andrew Hockett II				Lynn Bir		Olyle Zin Code)
	2	9a. Informant's Name/Relationship (Type, Print) James A. Hockett II (father)	19b. Mailing 1913	g Address (Street and Fluse Dr.,	d Number or F , Marri	tural Route Numbe ottsvill	e, MD 2	, State, 21p Code) 1104
nd 2 s alth a em 27	-	20 Mathed of Disposition 20	Ob. Place of Dispos	sition (Name of cemete	ery,	Date 2		City or Town, State
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'Medical aminer	Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions). Due to (or as a consequence of the conditions).	ce of):					Death
executed ian and ial - transit	dical E	d. UNPENDED AMENDED 7 DOT ME.		<u> </u>				
ords, P.O. Box 68760, wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial - transit	9	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown 9 Unknown	of death 5	Fetal death 3 Dther (Specify)	Ectopic pregn		23d. Date of Month	delivery Day Year ibute to the cause of death?
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Larry Harlee

07-08932 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner 1126 hrs Larry

4a. Facility Name (if not institution, give street and number) November 18, 2007 Harlee 4b. City, Town, or Location of Death 4c. County of Death 248 South Dallas Court **Baltimore** NA 5. Social Security Number 6. Sex Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYY) 9. Birthplace (State or Months **Director** Davs Hours Min 214-62-6895 1X M 2 Country) 9-6-1955 Usual Residence of Decedent Ę 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Md. NA death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 248 S. Dallas Ct 238 Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 White, etc. Married Yes 2 X No after Widowed 4 f Yes, Give Year Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. Divorced Yes 2X No specify: Specify: Black <u>م</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Oecedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12th grade NA Cook ARA Benix Food Service 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Clif Herrington Bertha Harlee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alonzo Harlee Brother 4235 Sheldon Ave., Baltimore, Md. permit. Pages 1 and 2 s
Department of Health a
Important: If item 27
injury or other traums 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11-24-07 Lansdowne. Md. Mt. Zion Cem. Donation 5 Other Specify: 21. Signature Funeral Service Licensee 22. Name and Address of Facility March F.H. East Mulai Whan North Baltimore, Ave 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit or Attending Physician: The law requires that the death certificate be execu Physician/Medical g physician a UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth for use as 3 Ectopic pregnancy Fetal death Month past 12 months? 2 Dav Year Pregnant at time of 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus: Asthma 1 Yes 2 No 3 Probably 4 V Unknown Division of Vital Records, Completed this certificate has been a director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 V No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other₄ Inpatient 2 ER/Outpatient 3 DOA this Nursing Home 5 Residence 6 ✓ Other: Scene ဂ 1 Yes funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natura the Hospital or Attendi Pending Yes 2 No To the Funeral Director: completely filled in by the 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

Laron Locke MD. Assistant Medical Examiner 200

29b. Signature and title of certifier

32 Registrar's Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 19, 2007

Registrar

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

				Plea							Ensure A	-	_	ible.	
			For State		State	of Ma	aryland				ealth and M	lental Hy	giene		
			Registrar	- (Final 88) 1-11	- 1 1			Cei	rtificat	e of L	Jeath	2. Date of De	Reg. No.	997	37454
	Physicia	an	1. Decedent's Name			h	Holm	~				Month	Day	Year	10-15 A M
	/Medic		Catherir 4a. Facility Name (/		Elizabet		Helm	II .	4b. City,	Town, or	Location of Death	Novembe		ty of Death	10:15 A.M.
	Examin	er	College		, g,, e						ville			ĺtimo	
	Funeral		5. Social Security N		6. Sex		e (In yrs. las		If Under	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	av. Year)	9. Birth	nplace (State or Foreign untry)
	Director		213-14-9 Usual Residence of		1 □ M 2 X F	94		Yrs.				June 6,	, 1913		hington
	land ow		10a. State	10b. County			10c. City, 7	Town or Lo	cation						10d. Inside City Limits
	Many a-f sh ffied	tor	Md.	Balti	more		Perry	/hall							1 □Yes χ 💢 No
	or 28	Dire	10e. Street and Nu						10f. Zip				10g. Citizen o		untry?
	ath w	Funeral Director	9219 Gree	enhouse:				1		2123			U.S		to the first
	ter de Items	nne	11. Marital Status 1 □ Never Marr	ried 2□ Man	Armed	ecedent Forces? s 2 □ I	Ever in U.S.	13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecity Yes or No Rican, etc.))- 14. H	ace - Amer ack, White	rican Indian, e, etc.
	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. Ind Mental Hyglene in marked other than "natural" or Items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	by	3 X Widowed		If Yes,				1 ☐ Yes	XX No	Specify:		Spec	ify: Wh	ite
5	72 hor	Completed	(Spec		t's Education st grade complete	d)		16a. Dece	dent's Usu	al Occupa	ation	ina	16b. Kind of		
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7	filed withii Hygiene. other than ent, the M		17. Father's Name	(First Middle.	Last)			ACC	<u>ounta</u>	nt_	18. Mother's Name	e (First. Middle	ACCOUI		
0	Mental arked o	To Be	Allen H		,						Glendol			,	
٩	2 shou and M is mar aumat	-	19a. Informant's N	ame/Relations	hip (Type. Print)			19b. Mailir	ng Address	(Street a	and Number or Rur	al Route Numb	er, City or Tow	n, State, Z	ip Code)
Ξ.	1 and 2 Health a em 27 is other trau		David L.	Helm -	son						e Cir. Pe				
<u>5</u>	一工るを		20a. Method of Disp		3 ☐Removal fro	m State	cerr	ce of Disponetery, crea	matory or c	other plac	e)	Date	20c. Location	0.00	Town, State
	permit. Pages Department of Important: If it any injury or c		4 □ Donation				MII.	ltop			S of Facility	24,2007	IDWSDF	1,110.	
ם מ	permit. Departr Importa any inju		21. Signature of Fu	Ineral service								Home,I	nc. 105	10 Yo	rk Rd. Md.
H			23a. Part1. Enter t shock, or hea	he disease, or art failure. List	r complications the	t caused	I the death. ne.	Do not ent	er the mod	le of dyin	g, such as cardiac	or respiratory a	irrest,		Approximate Interval Between
	Physician		Immediate Cause disease or condition	(Final on	a. C	100	vic of	Sofor	est	12	pulmon	asy d	iscare		Onset and Death UEans
	/Medical Examiner		resulting in death)		Due	to (or as	a consequer	nce of):		4		0			. 501/
		er	Sequentially list co	nditions, nmediate	b	to (or as	a consequer	nce of):	us						geer _
	uted ansit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	rlying injury	S .										
5	an an	Еха	resulting in death)	Ĺast	Due	to (or as	a consequer	nce of):							
0 / 00	eath certificate be executed attending physician and for use as the burial-transit	dical			d					·					
9 4 0	certific	sician/Medica	IF FEMALE:		23c. If yes,	outcome	pf pregnanc	cy					23d F	ate of deli	Venu
ב	death atten	ician	23b. Was deceden in the past 12 1 \(\sum \) Yes 2	months?	1□Liv 4□Pr	e birth egnant a	2 Fetal de t time of dea	eath 3	∃Ectopic p ∃ Other <i>(s</i> ;					nonth	Day Year
<u>;</u>	tt the oby the tached	Physi	9☐Unknown		9□Ur	known		-1-1-1							
ń	es the	ру Р	Part II. Other signi	ficant condition	ons contributing to	death b	ut not resulti	ng in the u	nderlying	ause give	en in Part I. ≺				the cause of death?
Č no	requir	ted	OC FICI	VAILL.	(CION	1000	1:46	- CASE	1.		1,1	11×			obably 4 Unknown
ה ה	has b	Completed	Peripho	naly	ascill	20	ivea	ia:	7	181/	pacro	24a. Was	DSV	b. Were au prior to death?	topsy findings available completion of cause of
פ	n: Th fficate or, pag		25. Was case refer	red to medica							OC Place of Park		ormed? 2 No	1 🗆 Yes	2 □ No
>	ysicia s cert	o Be	examiner?		Hospital:	☐ Inpatie	ent 2 EF	R/Outpatier	nt 3 🗆 D0	OA Othe	26. Place of Deater: 4XX Nursing Ho			ther (Spec	cifv)
5	ng Ph fter th	n: T	27. Manner of Deat	th 5		ite of Inju		8b. Time o	f :	28c. Injury Work			how injury occ		
5	tendir eath. or: At	atic	2 Accident	investi	gation				М	1 🗆 '	Yes 2 □No				
5	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	4 ☐ Homicide	determ	Zae. Pla	ace of inj ilding, et	ury - At home c. <i>(Specify)</i>	e, farm, str	eet, factor	y, office		28f. Location (City or To		nber or Ru	ıral Route Number,
	ospita hours uneral ly filled		29a. Certifier (Check only	1 Certifyir	ng Physician: To	the best	of my knowle	edge, deat	h occurred	at the tin	ne, date and place, pinion, death occur	and due to the	cause(s) and	manner as	stated.
	the H hin 24 the Fi	Medical	one)		and m	anner st		in and/or in		c. License		Ted at the time			
	T wit		29b. Signature end	7. Colonia	((00)	>				~ ~	222		29d. Date sign	07	7
	6		30. Name and edd	ress of person	who completed c	ause of d	leath (Item 2	3a) (Туре, 2 ту	Print)	8/10	D, Whi	to Ma	wh,	nd.	21236
	Sta		31. Date filed (Mon	nth, Day Year	6 2007 32	. Registr	ar's Signatur	re	Popula	1					
	Registr	ar				J. C. C.	As was	1	A CONTRACTOR OF THE PARTY OF TH	7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physicia<u>n</u> Lawrence Raymond Hebert 2007 Nov. 7:00 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Northwest Hospital Randallstown
If Under 1 Year | If Under 24 Hrs. **Baltimore** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 71 311-36-2168 Indiana Director 6/17/1936 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 → No MD Raltimore Baltimore Director o 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code iral", or items 23a or Examiner must be 6618 Bowman Hill Drive 21207 U.S.A.

14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 😾 No Specify: White Completed by 3 ☑ Widowed 4 ☐ Divorced "natural". 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Westinghouse permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lois Falls Hebert Raymond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael Thomas Hebert 14544 Jaystone Drive - Silver Spring, MD 20905 (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition TXBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) 11/29/07 Woodlawn, Md. Woodlawn Cemetery Puneral Home, Inc. Catonsville MD, 21228 21. Signature of Funeral Service Licensee Lemmer 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ple Immediate Cause (Final disease or condition resulting in death) . Mult: Physician /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any leading termine clause cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death P.O. I been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No has page; this certificate 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2XER/Outpatient 3 □ DOA 1 Yes 2 No 1 Inpatient ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) all 1 ☐ Yes 2 ☑ No 2 Accident 3 ☐ Suicide within 24 hours after death

To the Funeral Director:
completely filled in by the f 28f. Localion (Street and Number of Rural Route Number, City or Town, State) 6618 Bowman H. II Rd Gwyn Ocks, Maryland 21207 6 Could not be determined in by t Home Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 24 2007

State

31. Date filed (Month, Day, Year) Registrar NOV26

MU 6 Trimble 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HILL CT. Lut how : We, Md ZIOG3

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DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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10d. Inside City Limits

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1 Yes 2 No

State Registrar Mame and address of person who complete

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Year)

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ause of death (Item 23a) (Type, Print)

Greene

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32. Registrar's Sonature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ovember 4,200 **JOHNSON** SEAN Μ. /Medical 4c. County of Death 4b City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner tal saltimore Greneral N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y FEB 25 9. Birthplace (State or Foreign In yrs. last birthday) 5. Social Security Number **Funeral** Year. Days Hours 1 X M 2 ☐ F MARYLAND 1975 32 Director 217-84-4070 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10a. State 10b. County 1 Yes 2 No Director BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. r items 23a iner must b 21217 U.S.A. 503 DOLPHIN ST. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: XXNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 11th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ JOY JOHNSON BILLY ELLIS ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 503 Dolphin St., Baltimore, Maryland 21217 Timothy R. Johnson/Uncle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State LANSDOWNE, MARYLAND 11-21-07 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op-each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Dye)to or as a consequence of): **Examiner** UMONIU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury test initiated executions) Examiner arlure the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 🏈 that initiated events resulting in death) Last and Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 2 Fetal death Month Year in the past 12 months? Day ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No after death.

Director: After this certificate 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, P egistrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 6 Registrar

			For State	State o	f Marylan		artment of H		d Mental H	20	107	37460
Registrar 1. Decedent's Name (First, Middle, Last)					Cei					3. Time of Death		
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	Examin		4a. Facility Name (If not institution				4b. City, Town, or				ty of Death	
			NORTHWEST HO 5. Social Security Number	6. Sex	CENTER 7. Age (In yrs. li	ast hirthday)	RANDA If Under 1 Year	LLSTO			LTIMOR	
	uneral rector		215-42-8560	1□M 2XF	69	Yrs.	Months Days		lin. (Month, E	lay, Year) /1938		e (State or Foreign LAND
pur	>		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation				104	Inside City Limits
Maryla	f shore	ō	MD HOW	ARD		KRIDO					100.	1 XYes 2 No
the	r 28a- notif	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country?	?
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5-0036 72 hours after death with the Maryland	r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	Armed Fo	2∐XNo ve		Nas Decedent of Hi fYes, specify Cuba I□Yes 2 X No	ispanic Origin? In, Mexican, Pi Specify:	(Specify Yes or Nuerto Rican, etc.)	Bla	ace - American lack, White, etc.	
215-0036 Ithin 72 hours at ie.	atura ical E		15. Decedent (Specify only highes	's Education		16a. Deced	lent's Usual Occup	ation	working	16b. Kind of I	Business/Indust	try
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4 5	other th		10TH 17. Father's Name (First, Middle,	(not)		пс	OSEKEEP		Name (First, Middl		ESTIC	
五 · 章 章	0 0	To Be	WILLIAM MYE						DRED WI	,	une)	
Taryla 2 should and Men	7 is marke traumatic		19a. Informant's Name/Relationsh			19b. Mailir	g Address (Street a	and Number of	r Rural Route Num	ber, City or Tow	n, State, Zip Co	ode)
	Item 27 i other tra	19	STEPHANIE W	ALL / DA	UGHTER		5 SCARL	ET OAI				
of H	or ot		20a. Method of Disposition 1	3 ☐Removal from	State HO	ace of Dispo PKINS	sition (Name of patory or other plac UM CEMETER	e) 1 -	Date 1/27/07		- City or Town,	
thent	ortant: injury		4 □ Donation 5 □ Other (S) 21. Signature → Puneral Service		CH		CEMETER . Name and Addres				LAND, I	
perm Lepa	any i		21. Signature of Pullerar Service	Licensee .	a Solis	_	600 LIB		HOWELL			
70	(En		23a. Pal Enter the disease, or shock, or heart failure. List	complications that	aused the death						Ar	oproximate terval Between
Phys	sician		Immediate Couse (Final	1							Ö	nset and Death
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pet	nsit	nine	Sequentially list conditions, it cay, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):								
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the death certificate be executed	y the attending ph ched for use es tl	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	come pf pregnal birth 2 Fetal nant at time of de own	death 3	Ectopic pregnancy Other (specify)			I	ate of delivery Month Da	ıy Year
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VITAI H	s certificate has b lirector, page 2 s	S							per 1□ Yes	formed?	death?	X No
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P Ph	ar this aral dii	5	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date	npatient 2 ☐ E of Injury	28b. Time of	1 3 DOA	4 🗀 Nursin	g Home 5 Res	sidence 6 🗆O		
	r: Afte e fune	ation	16 Natural 5 ☐ Pending 2 ☐ Accident investig	9	th, Day Year)	Injury		k? Yes 2 □ No		. ,		
DIVISION tal or Attending s after death.	within 24 hours after death. To the Funeral Director: After this certific, completely filled in by the funeral director,	Certification:	3 Suicide 6 Could n 4 Homicide determi	inod 28e. Place	of injury - At horning, etc. (Specify	me, farm, str	eet, factory, office			(Street and Nun own, State)	nber or Rural R	oute Number,
he Hospil In 24 hour		edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								ed. ne cause(s)	
Tot	To T	Σ	29b. Signature and title of certifier	0 ~	. 1.		29c. License			_	ned (Month, Day	No
_			- Sedinger	1 111	Chia	W.C		1410		Moven	wer, 2	2", 2m7.
3			30. Name and address of person		e of death (Item	23a) (Type,		DER	MET MET		a 11	22
	Sta	te	31. Date filed (Month, Day, Year)	MOSVIT	egistrar's Signat	ure C	~ INTH	OALLS	TULN	mo	011	22
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** JER KUBERT /Medical 4a. Facility Name (If not institution, give street and number) Examiner JOHNS HOPKINS BRYVIEW Age (In yrs. last birtho **Funeral** 1 XM 2□F 68 449-50-4672 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town o r 28a-f show notified at Directo Columbia Maryland Howard 10e. Street and Number ns 23a or must be n 5595 Vantage Point Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1961–62 "natural", or Items 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) marked other than

17. Father's Name (First, Middle, Last)

1 ☐ Burial 2 X Cremation

20a. Method of Disposition

19a. Informant's Name/Relationship (Type. Print)

Jeaneen Jernigan/wife

4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens

Sinkler Jernigan

3 □Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

	2. Date of Month	r Death	Day	Year	3. Time of							
JERI	Nov			2003	8:05	AM						
	4b. City, Town, o	r Location	of Death			4c. County	of Deat	h				
1	BALT	IMO	RE									
yrs. last birthday	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of (Month	Day.	Year)		hplace (State o	r Foreigi			
68 Yrs.	Months Bayo	, rouro		Sept	20,	1939	Texa					
c. City, Town or L	ocation							10d. Inside Cit	ty Limits			
olumbia								1 □ Yes				
	10f. Zip Code				10	g. Citizen of	What Co	ountry?				
	21044				U	ISA.						
in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Or an, Mexica	spanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.) 14. Race - Ar Black, WI					nerican Indian, lite, etc.				
61-62	1 ☐ Yes 2 【XNo	Specify:				Speci	^{fy:} Wh:	nite				
16a. Dece	edent's Usual Occu e kind of work done DO NOT use retire	ing	1	6b. Kind of E	Kind of Business/Industry							
	cial Mode				P	Physics Lab						
		18. Moth	er's Nam	e (First, Mic	ddle, M	aiden Surna	me)					
		Beatı	cice	Traft	on							
	ing Address <i>(Str</i> ee) Vantage											
Ob. Place of Disp	osition (Name of ematory or other pla	(00)		Date	2	Oc. Location	- City or	Town, State				
	ike Cremat	,	11/2	23/07	E	Beltsv	ille	, MD				
	2. Name and Address Home							ox 784				
	Severly L						svil		<u> 2102</u>			
death. Do not er	nter the mode of dy			or respirato	ry arre	st,		Approximat Interval Bet Onset and I	ween			
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NOV, 20, 2007

Physician /Medical Examiner

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The law requires that the death certificate be executed

attending physician and for use as the burial-tran

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

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23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final HEMORRHA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctonic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide McertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

20b. Place of D

State Registrar

DR. RAHILA

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

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EASTERN AVENUE, BALTIMORE MD

State Registrar or Auxeury Ka 31. Date filed (Month, Day, Year) NOV 26

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Baltimore MD

30. Name and address of person who completed cause death (Item 23a) (Type, Print)

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2007

State of Maryland / Department of Health and Mental Hygien ? 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 8:00 A M **Physician** Albert Edward Keck 18. 2007 November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Woodlawn 2218 Southland Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral X**□M 2□F 89 213-05-2676 February 17, 1918 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylanent of Heatih and Mental Hygiene.

ant: if Item 27 is marked other than "naturel", or Iteme 23e or 28e-f ehov
ury or other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2X No Baltimore Woodlawn Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States of America 21207 2218 Southland Road e filed within 72 hours after deathed Hygiene.
I Hygiene.
Other than "naturel", or Iteme 230. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? SpecifyWhite 1 Yes 2 No 1 Never Married A Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chief Operations Specialist Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Olga Caroline Rothe Albert Patrick Keck ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Spouse) 2218 Southland Road, Woodlawn, Maryland 21207 Mrs. Albert E. Keck 20c. Location - City or Town, State 20a. Method of Disposition

X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Woodlawn, Maryland 21207 11/24/07 Woodlawn Cemetery permit. Page Depertment of Importent: If any Injury of any Injury of 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityLoring Byers Funeral directors, Ind 21. Signature of Funeral Service Licensee 8728 Liberty Road, randallstown, Maryland 21133 mon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atherosclerotic Vascular Immediate Cause (Final untinsum Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a dinsequence of: NA ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown this certificate has been signed I ral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No or Attending Physician: After this certification, I 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1. Natural 5 Pending within 24 hours efter death. To the Funeral Director: Al М 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) illed in by 4 | Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 29c. License number 21107 15 ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe Williems Avenue 449 206 31. Date filed (Month, Day, Year) strar's Signature State NOV 2 6 2007 Registrar

Registrar

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2973 Manchester Rd Manchest

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

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State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 40059388 11-23-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lock Rover Blud Baltimore, MO 21239 David Weismon 5601

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Day, Year) NOV 2 6 2007

4 Homicide

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month November 22,2007 6:05 A M Knighton Betty 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Joseph Richie House N/A Baltimore 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Months Days Hours 1 ☐ M 2 🔀 F 217-40-7708 64 <u>Maryland</u> May 5, 1943 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 1630 Joplin Street USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🏖 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Cleveland Forbes Lela McNeil 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1630 Joplin Street, Baltimore, Maryland Christopher Rasin Companion 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State NOvember Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4 Donation 5 ☐ Other (Specify) Dundalk, Maryland 26, 2007 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 21. Signature of Funeral Service Licensee 21222 7110 Sollers Point Road, Dundalk, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) esont Due to (or as a consequence of): Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Whiknown 1 ☐ Yes 2∏ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed 1+11 1□ Yes 2☑No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical **Examiner** Examine g physician and x

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Important: If ite
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Baltimore, Maryland 21215-0036

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23b. Was decedent pregnant in the past 12 months? 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?
1 Yes 2 No

29a. Certifier (Check only one)

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s), and manner stated.

29c. License number

d tale of certifier 29b. Signature a

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29d. Date signed (Month, Day, Year)

30. Name and address 31. Date filed (Month, Day, Year)

person who completed cause of death (Item PSa) (Type, Print)

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32 Registrar's Signature NOV 2 6 2007

State Registrar

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Division or Vital Records, P.O. Box 68760, within 24 hours a

To the Funeral I

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Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title pertifier November 26 2007 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E Idesbur, MD 21784 1645 liam Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar **ORIGINAL**

			1 - For State Registrar		partment of Health and I partificate of Death		2007	37468	
	Disconing		1. Decedent's Name (First, Middle, Last)		14	2. Date of Death Month	Day Year	3. Time of Death	
	Physici /Medic		Edward		Karczeski		21 2007	706 P M	
	Examir	ner	4a. Facility Name (If not institution, give street		4b. City, Town, or Location of Death	n	4c. County of Death	1	
			Johns Hopkins Bayire 5. Social Security Number 6. Sex		Baltimore If Under 1 Year If Under 24 Hrs.	10.5	Baltimor		
Ξ,	Funeral Director		5. Social Security Number 6. Sex 1 🖾 M	7. Age (In yrs. last birthday 90 Yrs.	Months Days Hours Min.	(Month, Day, Y	ear) Col	nplace (State or Foreign untry)	
			Usual Residence of Decedent	90		Nov. 13,	191/ Ma.	ryland	
	ed at		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits	
	Ba-f	cto	Maryland Baltimore	City Bal	timore City			MXYes 2 □ No	
	vith th	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Co	untry?	
	a 23	eral	3709 Bonview Avenue	Was Decedent Ever in U.S. 13.	21213	nasitu Vaa as Na	USA 14. Race - Amer	ion Indian	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "naturel", or itema 23s or 28s-1 show other traumatic event, the Medical Examinatings he notified at	by Funeral	1 Never Married 2 Married	was Decedent Ever in 0.5. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2XXNo Specify:	o Rican, etc.)	Btack, White		
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Nar	12 sh h and 7 le m raum	0 4	19a. Informant's Name/Relationship (Type,		ling Address (Street and Number or Ru				
	1 and 2 Health Iem 27 other tra		Gerard Karczeski (Sc 20a. Method of Disposition	20b. Place of Disp	2 Quenon Ct. Jarre		Md. 21084 c. Location - City or		
jo	00		1 Burial 2 □ Cremation 3 □ Remo	oval from State cemetery, cre	ematory or other place)		•		
Baltimore,			4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee	The second secon	eart of Jesus 11		altimore,	Md.	
Ba	permit. Departri Imports eny Inju		> E. J. Lassal	N	²² ୯assahn ଅଧିକ ଅଧିକ ଅଧିକ । 7401 Belair Rd. ।	Baltimore,			
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	To the within 2 To the complet	M	29b. Signature and title of pertifier		29c. License number		. Date signed (Month	n, Day, Year)	
					Res-000	N	ovember:	21,2007	
10	*1		30. Name and address of person who comple MARC Sovershire,	eted cause of death (Item 23a) (Type	Print) ten Avenue Rela	more Mi	yland Z	1224	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 6 2007	32. Registrar's Signature	Print) tern Avenue Belt				

		For 1 State	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Beg No 2 0 0 7 2 7 1 C 0											
		State Registrar 1. Decedent's Name (First, Mi	iddle took		-	Ce	rtificate o	t Deat	h		Reg. No	200	7 3	7469
Physicia	an		,	7714		т				2. Date of De Month	Day	y Ye		ie of Death
/Medic		Joseph 4a. Facility Name (If not institu			ne,	Jr.	4b. City, Town	or Locatio		Novembe		, 2007		.5 A ^M
Examin	er	Crofton Conva	-		h Con	tor		fton	iii oi Deatii		-			
Funeral		5. Social Security Number	6. Sex			ast birthday)	If Under 1 Ye	ar If Und	ler 24 Hrs.	8. Date of Bir	th	9.	Arunde 1 Birthplace (Sta	ate or Foreian
Director		579-18-0653	1) M	2□ F	86	Yrs.	Months Day	s Hours	s Min.	(Month, Da			Country) Maryla	
p .		Usual Residence of Decedent								Берс 1	U 9 I	721		
ırylar show	_	10a. State 10b. Cou	nty		10c. City,	, Town or Lo	cation							e City Limits
e Ma 8a-f s	Director		e Arund	le1		Croft	on						'	Yes 2 📉 No
or 2	Dire	10e. Street and Number					10f. Zip Code	9			10g. Cit	izen of What	Country?	
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item item ner n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ M	Jarried 12.	Was Decedent E Armed Forces? 14 Yes 2 ☐ N	ver in U.S	5. 13.	Was Decedent of If Yes, specify C	t Hispanic (uban, Mexic	Origin? (Spe can, Puerto	ecify Yes or No Rican, etc.))-		merican India /hite, etc.	٦,
rs aft	by F	3 Midowed 4 □ Divor	ced	lf Yes, Give Year or Dates:	O		1⊡Yes 2XIN	o <i>Speci</i>	ify:			Specify:	White	
2 hou		15 Dece	dent's Education	on.		16a. Dece	dent's Usual Occ	upation			16b. K	ind of Busine		
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d with	Completed	12	-	College (1-401 54	'	Inte	11igenc	e Ana	lyst		Go	vernme	ent	
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Ment Ment arked	To	Joseph Ma	rion	Kline,	Sr.]]	Doroth	ny Lo	uise	Pod	1e	
2 sho and is ma		19a. Informant's Name/Relati	onship (Type. i	Print)		19b. Maili	ng Address (Stre	et and Nun	nber or Rura	al Route Numb	er, City o	or Town, Stat	e, Zip Code)	
and lealth m 27 her tr		Donald S. Kli	ne/son				Pleasan	t Mea						
ges 1 t of F if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 🏋 Crematic	on 3 □Remo	oval from State	20b. Pla	ace of Dispo emetery, cre	osition (Name of matory or other p	lace)	1	Date	20c. Lo	ocation - City	or Town, Stat	е
tmen tant:		4 □ Donation 5 □ Othe	er (Specify)		W Ar		Cremat		1	1/2007	0de	nton,	Mary1	and
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Serv	ice Licensee	homas		l D	2. Name and Add onaldso: 411 Ann	n Fund	eral I	Home & 1 Oden	Crem	atory, Maryl	P.A. and 21	113
		23a. Part1. Sater the disease shock, or heart failure.	, or complication	ons that caused ause on each line	the death. e.								Approx	
Physician		Immediate Cause (Final disease or condition		Cardia									Onset a	and Death
/Medical		Due to (or as a consequence of):												
Examiner	_	Sequentially list conditions,	b											
sit ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~	Due to (or as a	a consequ	ence of):								
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ficate be executed physician and s the burial-transit					,	quence of):								
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	edical		d											
leath certif attending I for use as	N	IF FEMALE: 23b. Was decedent pregnant		If yes, outcome p								23d. Date of	delivery	
death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		1 ☐ Live birth 2 4 ☐ Pregnant at			⊒Ectopic pregna ⊒Other <i>(specify,</i>					Month	Day	Year
ires that the de signed by the a be detached i	Physician/M	9 ☐ Unknown		9∐Unknown										
as tha	by P	Part II. Other significant con-	ditions contrib	uting to death bu	t not resul	Iting in the u	nderlying cause	given in Pa	rt I.	23e. Did	tobacco	use contribut	e to the cause	of death?
w require been signal	ed	Dementia								1 🗆	Yes 2	□ No 3□	Probably 4	Unknown
ne law n has be ye 2 sho	Completed									24a. Was		24b. Were	autopsy findi to completion	ngs available
The ate h	EO.									perfe 1⊟ Yes	ormed?	deat	h?	or cause or
ysician: Th is certificate director, pag	Be (25. Was case referred to med examiner?						26. Pla	ace of Deat	(Check only				
Physician: this certificaral director, p	ပ	1 ☐ Yes 2 ☐XNo	Hosp	1 🔲 inpatier		R/Outpatie	IL 3 DOA		Nursing Ho	me 5□Res	idence	6 □Other (Specify)	
aling F	on:	27. Manner of Death 1X Natural 5 ☐ Per	nding	8a. Date of Injur! (Month, Day)		28b. Time o Injury		jury at ork?		28d. Describe	how inju	ry occurred		
ttend death ctor: / the	icat	3 Suicide 6 □ Co	estigation uld not be	8e Place of iniu	ry - At hor	me farm st		☐ Yes 2		28f Location /	Stroot or	ad Mumber o	r Bural Bauta	Marmhar
al or A s after al Direct	27. Manner of Death 1 X Natural 1 X Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. 1 Ime of Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 2 No 1 Yes 2 No 28c. Injury at Work? 2 No 1 Yes 2 No 28c. Injury at Work? 2 No 28c. Injury at Work? 2 No 28c. Injury at Work? 3 Suicide 4 Homicide 4 Homicide 28c. Injury at Work? 3 Suicide 4 Homicide 28c. Injury at Work? 4 Nort? 5 Yes 2 No 28c. Injury at Work? 6 Could not be determined 28c. Injury at Work? 6 Could not be determined 28c. Injury at Work? 6 Could not be determined 28c. Injury at Work? 6 Could not be determined 28c. Injury at Work? 6 Could not be determined 28c. Injury at Work? 6 Could not be determined 28c. Injury at Work? 6 Could not be determined 28c. Injury at Work? 6 Could not be determined 28c. Injury at Work? 6 Could not be determined 28c. Injury at Work? 6 Could not be determined 28c. Injury at Work? 6 Could not be determined 28c. Injury at Work? 6 Could not be determined 28c. Injury at Work? 6 Could not be determined 28c. Injury at Work? 6 Could not be determined 28c. Injury at Work? 6 Could not be determined 28c. Injury at Work? 6 Could not be determined 28c. Injury at Work? 6 Could not be determined									r Hurai Houle	Number,			
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (29a. Certifier (Check only one) Certifier 2 ☐ Medi	fying Physicia ical Examiner:	an: To the best of On the basis of and manner sta	examinati	vledge, deat ion and/or ir	h occurred at the	time, date y opinion, o	and place, death occur	and due to the red at the time	cause(s , date an) and manne d place, and	r as stated. due to the cau	use(s)
To th Within To th COMP.	Me	29b. Signature and title of cer	tije	,			29c. Lice	nse numbe	er		29d. Da	ite signed (M	onth, Day, Ye	ar)
9			1					D570	25		11	-20-	-07	
111		30. Name and address of per	son who compl	leted cause of de	eath (Item	23a) (Type,	Print)			λ.				
7 1		Aditya Ch	10pra	1/1.D. (e00	Kidge	ly Ave	nue:	#231	Ann	apol	IS, W	D 21	401
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature														

07-08920 **Edward King**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day November 17, 2007 Medical Examiner 1815 hrs Edward King 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2120 E. Fayette Street **Baltimore** 5. Social Security Number unk 6. Sex If Under 1 Year If Under 24Hrs. **Funeral** Age (In yrs, last birthday) 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Director CountryMaryland 1X M 2 F 75 Oct 21, 1932 Usual Residence of Decedent any 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Y Yes 2 No MD Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 2120 E. Fayette Street 21202 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 X Never Married Married 2 X No Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry un Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 0 janitorial and Mental Hygiene 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) event, Be Agnes Peters <u>Bernard King</u> ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ant of Health and M nt: If item 27 is m: 21237 1219 Kendrick Road Rosedale, MD Matthew King/nephew 20a. Method of Disposition Baltimore, 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State portant: Donation 5 X Other Specify: in state 21. Signature of Funeral Service Licensee Ronald S. Ward State and Address of Facility and 655 W. Baltimore Street 222 21201 Baltimore, MD I. Enter the disease, or complications **Physician** caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and List only one cause on each line /Medical a. Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease :aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -UNPENDED **AMENDED** IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? Yes 2 V No 1 Yes To the Hospital or Attending Physician: ' within 24 hours after death. To the Funcral Director: After this cerific 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Other; Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 V Yes Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 V Natural Yes 2 No Pending the Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 20, 2007 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MOV 2 Registrar

DHMH 17 Rev 1/2001

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ORIGINAL

	Baltimore, Maryland 21215-0036
Phy	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hydiene.
sic	Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show
cia	any Injury or other traumatic event, the Medical Examiner must be notified at
	2000

Physician

/Medical 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) 05/23/1913 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 213-20-4522 Director MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 1 No MD HARFORD Director **FALLSTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2114 FOLKSTONE DRIVE U.S.A. 21047 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: ģ WHITE 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **STENOGRAPHER** REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JONATHAN WEINER CECILIA POZNANSKY 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE ALLEN KRAUSE / SON 2114 FOLKSTONE DRIVE - FALLSTON, MD 21047 20a. Method of Disposition 20b. Place of Disposition (Name or SHAARET TFILOH CONG. 11/21/2007 1 Mag Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, Part1. Int. I the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1. Immediat Cause (Final disease or condition resulting in death) weeks Ancrexia Due to (or as a consequence of): Examiner Dumenta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Wissig Parkinson's and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2/10 No Month Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed' 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 15513 Fach Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31295 11/19/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KIOSZ 6701 N Charles St Sute 4202 Trusm md 71700 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Marie S. 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** PM 2000 G. Christine Ligon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Hospital of Baltimore Himore inai 8. Date of Birth (Month, Day, Year) 09/20/1935 If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number if Under 1 Year **Funeral** Days Hours Min 1 □ M 2**X** F 215-32-0185 72 Director Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturat" any highly or other traumatic excessions. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 No Funeral Director Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21215 3029 Woodland Avenue 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Black Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Housekeeper 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christine McCargo 2 Arthur Webb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3029 Woodland Avenue, Baltimore, Maryland 21215 Fdmond Ligon / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/29/2007 Landsdowne, Maryland Zion Cemetery 21. Signature of Funeral Service Licensee The Derrick C. Jones F/H, P.A. Ave., Baltimore, Maryland 21215 4611 Park Hgts. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner ancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as a consequence of): Examiner The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 nonths? 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autonsy perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ✓ Ves 2 □ No 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 EB/Outpatient 3 □ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Ye 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) and title of certifit

Registrar DHMH 17 Rev 1/2001

State

29b. Signature

31. Date filed (Month, Day,

nd address of person

NOV

6 2007

30 Name

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

XM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend 10c, 10e, & 10f, perInf. 0874, 12clentificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOV 200 John A. Lynch /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner HOSDIN OF Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F Director 82 220-18-7548 09/09/1925 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or items 23a or 28a-f show notified at 1 ☐ Yes 2 No Director Baltimore Baldwin-**Baltimore** MD 10e. Street and Number 4237 Sheldon Avenue 10f. Zip Code 10g. Citizen of What Country? 21206 the Medical Examiner must be U.S.A. Funeral Road 21013 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Binder Printing Industry permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If item 27 Is marked other th any injury or other traumatic event, the once. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ella Murphy 2 Carol John Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Jerome E. Murphy (cousin) Box 9706 Baldwin, Maryland 21013-0706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11/23/2007 | Baltimore, Maryland New Cathedral Cem,. 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licenses 6 a 11750 Belair Road - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to in minimum cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending shoushand. as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2□ No 3 ☐ Probably 4 ☐ Inknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ 100 24a. Was an autopsy performe 2 - No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 🔲 Inpatient 3□ DOA 2 DFR/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury M 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier License number 29d, Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 51513 31. Date filed (Month Registra s Signature State 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 14 2007 **Physician** 2:30P M Frances Lucas /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Wicomico Salisbury Wicomico Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🔯 F Director 219-22-0866 June 12, 1916 Virginia Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes 2√ No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or edical Examiner must be 1700 E Gate Drive #604 21802 USA Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: white à 3X Widowed 4 □ Divorced Completed of Health and Mental Hygiene.
Item 27 Is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) healthcare 12 registered nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 Is marked oth Be Bessie Pearl Shrieves Frank Drummond Parks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and ment of Health and 27 Is 241 Seneca Terrace PAsadena, MD 21122 John H. Lucas III/son : If Item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit Page Deparment o Imporant: If 4∑Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S, Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director 23a. First. Enter the distast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, styck, or heart failure. List only one cause, in each line. Immedian—ause (Final disease or condition resulting in death) **Physician** PNEUMONIA. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No DEMENTIA 24a. Was an page 2 s autopsy performed? certificate 1 Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 🔲 Inpatient this 27, Manner of Death 28a Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 1 ☐ Yes 2 ☐ No death.

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician:

Maryland 21215-00

To the Funeral Director: After th completely filled in by the funeral after death

5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3□ Suicide determined 4 ☐ Homicide

29a. Certifier

(Check only one)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 0 0063199 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

614 Easternshore Dr Salisbury MD 21804 Yogesh Vohra M.D.

State Registrar

Medical

31. Date filed (Month, Day, Year) NOV 2 6 2007



To the Hospital within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend state of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Manning - oret 20th 2007 MAY1:00 November /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSPITAL BALTIMORE ST. AGNES If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth Septing, Pay, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2**X**F 60 Director Maryl and Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura!" --- any lijury or other traumatic exercises. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Manning umwri corge ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dwayne Manning 20c. Location - City or Town, State 20a, Method of Disposition Number 2 ☐ Cremation 3 □Removal from State 4 □ Donation 75 □ Other (Specify) mD. uneral Service/Lice 455 23a. Palm, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock ownear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final **Physician** UROSEPSIS 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ADENOCARCINOMA PANCREAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division or Vital Records, WITE Cirrhosis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an insufficience performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mallika. A P22257 November 2015 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

MALLIKA ANGITIPALLI

NOV 2 6 2007

31. Date filed (Month, Day, Year)

MARZING

BALTIMORE

ND - 21229

, ST. AGNES HOSPITAL

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

NOV

07-09036 Dorothy Brown McCov

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			Route 140 & Greenspring Valley Road Owings Mills Baltimore County Buttoniace (State of the Autoproceed of Birth	r Foreign
	ineral rector	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 03 18 1945 6. Sex 7. Age (In yrs. last birthday) 4. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 4. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of Country) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of Country) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of Country) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of Country) 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State of Country) 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State of Country) 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State of Country) 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State of Country) 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State of Country) 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State of Country) 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State of Country) 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State of Country) 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State of Country) 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State of Birth (MM/DD/YYYYY) 9. Birthplac)
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MD rd 2 sho	alth and m 27 is aumati		Dere K. J. Mc Coy (Son) 36 Hunt Cup Cir., Ownes NI. IIS, MD 211 202. Method of Disposition 203. Method of Disposition 204. Place of Disposition (Name of cemetery, Date J 20c. Location - City or Town, State	!
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Baltimore, Permit. Pages I a	portmen portant ury or		4 Donation 5 Other Specify: 21 Symptoms of Funetal Service Licensed 22. Name and Adjess of Facility GOODE Time to Service Se	2 20
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		her	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
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Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and compleally tilled in by the fineral director, page 2 should be detached for use as the burial - transit	eted I		
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visic	or Atte fter dea Director	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Major Road / Highway 1 Mov 22, 2007	umber, City
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	4		Theodor M. Fred My uns	
10			30. Name and address of person who completed cauco of death (Itel) 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
-		Stat	te 31. Date filed (Month, Day, Year) 6 2007 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 7 37478 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 23 **Physician** Mary H. Mislyan 2007 November 2:25p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll Sykesville Fairhaven If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year Apr 12 19 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** Days Hours 1 ☐ M 2 🙀 F PA 165-10-8630 1913 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 'natural', or items 23a or 28a-f show diral Examiner must be notified at MD Carrol1 Sykesville 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21784 USA 7200 Third Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 δ 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) U.S. Government College (1-4or 5+) civil service clerk permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If Item 27 is marked other thriany or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Hazuda Mary Salaki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1245 Crows Foot Rd., Marriottsville, Lawrence Mislyan (son) 20b. Place of Disposition (Name of cemetery, crematory or other place)
All County Cremation 11-26-07 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Page Haight Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death almonary Immediate Cause (Final Embolism **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): (Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 ☐ Ectopic pregnancy detached for Month 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 ☐ Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown Completed dichetes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform cerebrovascular 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4x Nursing Home 5 Residence 6 Other (Specify) 217 No ၉ 1 ☐ Yes this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After the Funeral Director of the Funeral Director of the foundation of 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

State

29b. Signature and title of cedifier

31. Date filed (Month, Day, Year)

Miam

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jan

6

MI)

1645

32. Fagistrar's Signature

Liber

29c. License number

29d. Date signed (Month, Day, Year)

Road Eldersburg MD 21784

Division of Vital Records, P.O. Box 68760, To the Funaral Director: After this certific completely filled in by the funeral director, within 24 hours e To the Funaral [

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1006279 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who Maryland Lavouich Universit 31. Date filed (Month, Day, Year) 32. Registrar's Signature

15

State Registrar

		1	For State Registrar	State of	Maryland / Do	epartment d Certificate		ind Me		ene g. 12 0 0	7	37480
4	Physici	-	Decedent's Name (First, Mid		_			2	Date of Death Month	Day	Year 2007	3. Time of Death 5:25 P M
Jan 1	/Medic Examin		Fdith L. Mily 4a. Facility Name (If not institut.		per)	4b. City, Tov	wn, or Location of	f Death	11	4c. County		J.23 I
		35	Oak Crest Vi	llage Care C	enter	Park	ville, M	Maryla	and	Bali	timor	e
ŝ,	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birth	day) If Under 1 Y		24 Hrs. 8 Min.	Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign
	Director		220-18-4317	1□M 2 X F	83 Y	rs.		0	8/06/19	24		ginia
	and w	1	Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. City, Town	or Location					1	0d. Inside City Limits
	Marylar f ehow ied at	ō	MD Balt	timore	Parkto	n						1 ☐ Yes 2√ No
	r 28a-f ehow	Director	10e. Street and Number	LINOIC	Tarke	10f. Zip Co	de		10	g. Citizen of V	What Coun	try?
	= 0 M		17822 Forest	ton Road		211	20			U.S.A		
		Funerai	11. Marital Status	12. Was Deced	ent Ever in U.S.	13. Was Decedent If Yes, specify		gin? (Specif	ty Yes or No-	14. Rac	e - Americ	
9	or Ite		1 Never Married 2 M	arried 1 ☐ Yes 2	ĭXNo	1 ☐ Yes 2X		, r doito i in	2011, 610.7	Specify		91C.
9	hours after urel', or its	d by	3 X Widowed 4 Divorce	ed Year or Date	es:						Whi	
5	22 and	Completed		ent's Education hest grade completed)	(Decedent's Usual O Give kind of work d life. DO NOT use re	lone during most	of working	1	6b. Kind of Bi	usiness/Ind	dustry
12	within ene. than "	шc	Elementary/Secondary (0-12) College (1-4	lor 5+)		ŕ			·Ioatow	n Elo	ctric Co.
d 2	ljed lygi lher nt. 1	ပိ	17. Father's Name (First, Middl	e, Last)	<i>F</i>	Assembler		r's Name (I	First, Middle, M			etrie w.
an	o to b	To B	George Isenho	nur			Arti	ie Rit	chie			
Maryland 21215-0036	d 2 should be f th and Mental P 7 ie marked of traumatic eve	-	19a. Informant's Name/Relatio		19b. I	Mailing Address (St				City or Town,	State, Zip	Code)
	5 章 Z T		Doreen A. M:	iller (dauc	hter) 1	17822 For	eston Ro	oad -	Parkto	n, Mar	yland	21120
Baltimore,	s = = 0		20a. Method of Disposition		20b. Place of D	Disposition (Name of crematory or other	of r place)	Dat	9 2	Oc. Location -	City or To	wn, State
E	Page ment o ant: If ury or		1 Burial 2 ☐ Cremation Donation 5 ☐ Other		are	Valley M		11/23	/2007 1	imoniu	ım. Ma	arvland
alti	permit. Pag Department Important: I eny injury c		21. Sign ture of Funeral Service	certicensee		22. Name and A	ddress of Facility	E. F.	Lassa	hn Fun	eral	Home, P.A.
8	8258		Method	1285cm		11750 Be	lair Roa	ad - I	Kingsvi	lle, Ma	aryla	nd 21087
	Physician /Medical Examiner porusi-Iransil	Examiner	shock, or heart failure. L' Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a):	emention	Q				Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be exite has been signed by the attending physician age 2 should be detached for use as the burian	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 ments? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live birt	ome of pregnancy th 2 Fetal death nt at time of death	3 □Ectopic pregr 5 □ Other (specif				1	te of delive	ory Day Year
	res that tigned by	y P	Part II. Other significant cond	itions contributing to dea	th but not resulting in t	the underlying caus	e given in Part I.		23e. Did toba	acco use cont	ribute to th	ne cause of death?
rds	uires n sign	d by	duschagia	, peripheral	uscular	diséase			1 ☐ Yes	s 2 🗆 No	3 Prob	ably 4 Unknown
8	aw requir is been si 2 should i	Completed	37 0	/!					24a. Was an		Were auto	psy findings available
Re	The lav	шо						_	autopsy	ed?	prior to coi death? 1 □ Yes	mpletion of cause of
ta		o l	25. Was case referred to medi-	cai			26. Place	of Death /	1 Yes 2		1 1 1 1 1 1 1 1	2 NO
>	lysici is cel direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🔲 Ing	patient 2 ER/Outp	patient 3 DOA	Other		5 Resider		er (Specif	Y)
0	Attending Physician: r death. ector: After this certific by the funeral director.		27. Manner of Death 1. ☑Natural 5 ☐ Pene	28a. Date of (Month,	Injury 28b. Tir Day Year) Inj	me of 28c.	Injury at Work?		d. Describe how			
<u>Ö</u> .	ttendir death. ctor: Al	atic	2 Accident	stigation		М	1 Yes 2 N	No				
Division of Vital Records,	- 9	Medical Certification:	3 ☐ Suicide 6 ☐ Coui 4 ☐ Homicide dete	mined 28e. Place o	f Injury - At home, farr j, etc. <i>(Specify)</i>	n, street, factory, of	ffice	28	f. Location (Str. City or Town,	eet and Numb State)	er or Rura	l Route Number,
7	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	ŭ	29a. Certifier 1 Certifi	ying Physician: To the b	est of my knowledge	death occurred of the	he time date and	d place as	d due to the co	usa(s) and m	anner as a	aled
	24 hos Fun etely	dice	(Check only 2 Medic one)	al Examiner: On the bas	is of examination and	or investigation, in	my opinion, deat	th occurred	at the time, da	te and place,	and due to	the cause(s)
	ro th	Me	29b. Signature and title of certi			29c. Li	icense number		29	d. Date signe	d (Month,	Dey, Year)
	- > E 0		> Fa.	10	MD	\cap	617A	5		11/1	9/1	
	^		30. Name and address of person	on who completed cause	of death (Item 23a) (T		0170			141	110/	
	8		Etosha P	Pixon 88	00 Wal	ther Bli	rd Po	idevi	lk 1	1021	234	İ
	Sta Registi		31. Date filed (Month, Day, Yes		gistrar's Signature	rade	/	,	/			

P.O. Box 68760, Division or Vital Records, hin 24 hours after death the Funeral Director: Hospital within 2

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and the of pertifier

Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

225, Greene Street

ORIGINAL

29c. License number

29d. Date signed (Month. Dav. Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fb 8874 12-3-07 yt State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** sence 20 /Medical 4a. Facility Name (If not institution, give street and nu 4b. City, Town, or Location of Death 4c. County of Death Examiner ltimore 13a NA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Yrs 213-32-7144 70 **Director** 1-1-1937 Md. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Md. NA Baltimore 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1012 Marlau Dr. 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 **∭**Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Driver <u>Bus Driver</u> permit. Pages 1 and 2 should be filed very pearment of Health and Mental Hygis Important: If item 27 Is marked other any injury or other traumatic event, the injury or other traumatic event, the secont is the contract of t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Sandy Montgomery Alice King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1012
1020
Marlau Dr., Baltimore, Md. 21212 19a. Informant's Name/Relationship (Type. Print) Ann D. Montgomery Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 11-28-07 Owings Mills, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F.H. East 3rup Mila 1101 E. North Ave., Baltimore, Md 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ement,a in Known /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760. ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy
performed

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Maprier of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bordevard, Baltimore, Margland Raven 3900 Lah, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Registrar DHMH 17 Rev 1/2001

State

Thomas Bi 31. Date filed (Month, Day, Year)

32./Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day MESENBRINK Month **Physician** EDERICK W. 22 2607 NOVEMBER /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner St. Agnes Hospital Himore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 X M 2 ☐ F Hours 214-26-8646 77 Director 7/21/1930 MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notified at Catonsville MD Baltimore Director 1 ☐ Yes 2 ☐ No 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? a or 21228 USA 1502 Frederick Rd. "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. ant if item 27 is marked other than "natural", or the ury or other traumatic event, the Medical Examine: ury or other traumatic event, the Medical Examine: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2, K No Specify: Specify: þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) firefighter EMT fire dept. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha (unknown) Frederick Mesenbrink ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 3385 Ferry Landing Road, Dunkirk, MD. 20754 19a. Informant's Name/Relationship (Type. Print) Christine Mitchell, daughter Department of Health Important: If item 27 any injury or other troonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 11/26/07 Catonsville, MD Metro Crematory 22. Name and Address of Facility Sterling of Catonsville Inc., 1630 Catonsville, Md. 21228 21. Signature of Funeral Service License Ashton Schwab Witzke FH Edmondson Ave., Lemmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Directo for as a nonsecuence of Examiner il any teaching to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1/0 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MS D36942

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

Frederick Rd. BALTIMORE, My 21228

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mp.

1009

32. Bigistrar's Signature

		•	For State Registrar	State of Ma		d / Depa		t of H	ealth a			iene g. No.	07	374	85
w.	Physici /Medio		1. Decedent's Name (First, Middle, Li	1. Mc	Co	ok					2. Date of Deat Month	Day 17	Year 2007	3. Time of 3:30	
	Examin Funeral Director	er	5. Social Security Number 6.	ice At 7		Loke ast birthday) Yrs.	Sa	115%	If Under,	4	8. Date of Birth (Month, Pay, Aug 11,	1010	9. Birthp County New	lace (State o	r Foreign
	D D	etor	Usual Residence of Decedent	ster	10c. City	Town or Lo	n					ty Limits			
	eath with the 18 23e or 2 must be no	Funeral Director	10e. Street and Number 53 Brandywine I	rive	ver in 115	3 13 1	10f. Zip	21	811	nin? (Sne		0g. Citizen o	USA		
900	nours after de urai', or Item Il Exumment	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			1 ☐ Yes 2	2 ∑ No	Specify:	n, Puerto	ecify Yes or No- Rican, etc.)	Spec	lack, White,	etc. te	unk
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: If item 27 is marked other than "natural", or Items 23a or 28a-f show aimportant: If item 27 is marked other than given and the notified at ODEs.	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 12		+)	life.	dent's Usua kind of wor DO NOT us Creta	k done d e retired,	luring most	t of worki		16b. Kind of			
ryland	should be filed withir nd Mental Hyglene. imarked other than imatic event, the Ma	To Be (17. Father's Name (First, Middle, Las John Andrianos			405 M-17	- 444	(2)	Fra	anzi	ska Rich	iter		0-1-1	
	ss 1 and 2 st of Health and item 27 is n r other traun		19a. Informant's Name/Relationship Andrew McCook/ 20a. Method of Disposition	son	20b. Pl	3008 ace of Dispo	Yanke	e C1	Lippe	r Dr	ive Las	Vegas	, NV 8	9117	
Baltimore,	permit. Pages Department of H important: If ite any injury or of		1 ☐ Burial 2 ☐ Cremation 3 l 4 ☑ Donation 5 ☐ Other (Spec 21. Signature of Euroral Service Dice RONALO	ify)						ðard	655 W.	Balti	nore S	treet	
	Physician /Medical Examiner		a. Part1. Enter the diseas or cor shock, y heart failure. List only Immediate Cause (Final disease or condition resulting in death)	np i ations that caused y one cause on each lin	the death e.	Do not ent		e of dying	g, such as	cardiac d	1 or respiratory arro DDBR			Approximat Interval Bet Onset and	ween
68760,	ficate be executed physicien and is the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to minterclate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a d.											
.O. Box	The law requires that the death certifica we has been signed by the attending phoage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 3☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pre Other (spe						Date of delive Month		Year
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death bu	ıt not resu	ilting in the u	nderlying ca	ause give	en in Part I		23e. Did tob	oacco use co es 245 No			death? Unknown
		Completed			_							med?	b. Were auto prior to co death? 1 Yes	psy findings mpletion of c	available ause of
Division of Vital	% ≤ p	Certification; To Be	25. Was case referred to medical examiner? 1 Yes	he	Y Year)	ER/Outpatier 28b. Time of Injury	M 2	8c. Injury Work	9r: 4 □ Nu	rsing Ho	me 5 Reside	ence 6 Co	urred		
Div	o the Hospital or Attending Phithin 24 hours after death. o the Funeral Director: After the mpletely filled in by the funeral		4 Homicide determined	hysician: To the best of	of my know	vledge, deat	berruppo r	at the tim	ne, date an	d place,	281. Location (St City or Town and due to the c	n, State) ause(s) and	manner as s'	tated.	
a 2	To the Howithin 24 To the Fu	Medical	(Check only / 2 Medical Exa	miner: On the basis of and manner sta	examinat ited.	ion and/or in		. License	number		2	9d. Date sig	ned (Month,	Day, Year)	
			30. Name and address of person who	is COAS	THE	1105	Print)	DU	053	4/0		57-54	Shun	911	21,0
,	Sta Registi		31. Date filed (Month, Day, Year) NOV 2 6 200	32. Registra	ar's Signat	ture South							,		

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a

To the Funeral !

Registrar DHMH 17 Rev 1/2001

State

one)

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Good

NOV 2 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FasiL B. Alenw

32. Registrar's Signature

Lasham

RD

29c. License number

MD 20706

D65909

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Johnny Homer Neil 9:00 P M 25, 2007 /Medical November 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Nursing Center Timonium Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 02/26/1944 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1700 M 2 □ F 63 Director 212-44-8619 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ral, or items 23a or 28a-f sho Examiner must be notified at Maryland Baltimore Director Essex 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Branch Street 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. MXYes 2□No If Yes, Give Vietnam Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2CXNo Specify: White ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Shipyard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Burton Neil Nellie Patricia Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Anna M. Neil - Wife 11 Branch Street, Essex, Maryland 21221 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem Garden 11/29/2007 Middle River, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Service Licenses Reclair Part Enter the disease, or application at cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List any one was on each line. 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Ulisaas or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1∐ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 2 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗓 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) tle of certifier 43725 11/26/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 21 2007 NEEDLE DOROTHY 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE BALTIMORE BRIGHTON GARDENS If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 02/18/1913 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months 212-22-6808 94 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No MD N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7111 PARK HEIGHTS AVENUE APT. 402 U.S.A. Race - American Indian, Black, White, etc. 21215 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **HAMBURGER** MOLLIE **JACOB APPLEFELD** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3518 BARTON OAKS ROAD - BALTIMORE, MD. 21208 MOLLIE N. SMULYAN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON CHIZUK 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/22/2007 BALTIMORE, MD AMUNO CONG ame and Address of Facility 21. Signature Aneral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Conset and Death 23a. Part 1. Enter the disease complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atheroscierotic Cardiovascular Disease disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cardion youath y Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed chronic kidney disease 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 ROther (Specify) A 55 15 test 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

certificate be

Physician

/Medical

Examine

Funeral

Director

ns 23a or 28a-f show must be notified at

7 is marked other than "naturai", or items 23a traumatic event, the Medical Examiner must b

72 hours after death

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permit. Pages 1 and 2. Department of Health an Important: If item 27 is any injury or other trau

Physician

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Saltimore, Maryland 21215-0036

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Funeral

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Certification:

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4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

P.O. | Division or Vital Records,

within 24 hours a To the Funeral C

State Registrar

nours after death.

neral Director: After this

filled in by the funeral d

aun L. Belitt, M.D

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

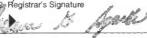
00058676

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karen L. Babitt

4000 old court Road, suite 301, Baltimore, MD 32 Registrar's Signature



07-09076 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Nickolas William Otte 2007 37489 1- For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 24, 2007 Nickolas Otte 0155 hrs William Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Baltimore County** I-695 & SR-702 If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Director 215-11-6634 23 07/31/1984 Country) Maryland 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No 28a-f show Maryland Baltimore Essex Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 702 Norris Lane 21221 U.S.A. Ö 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funer If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Yes Specify: White If Yes, Give Year Yes 2 X No specify: 3 Widowed 4 Divorced Examiner <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical and Mental Hygiene. 27 is marked other than 12 Iron Worker Local 16 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Nickolas Dean Otte Debby Laura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Essex, Maryland 21221 Debby Laura Lane - Mother 702 Norris Lane t of Health art: If item 2 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Baltimo permit. Page Department o Important: injury or oth Gardens of Faith Cem. 11/27/2007 Overlea, Maryland Donation 5 Other Specify 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part I. Enter the disease or complications failure. List only one cause on each line. Approximate Interval prications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and /Medical Death Multiple injuries caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause Disease or itsiury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed sician/Medical UNPENDED AMENDED Box 68760. 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown g Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ð 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has performed? death? ✓ Yes 2 1 V Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: Other: DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 After this 1 V Yes 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Nov 24, 2007 Subject passenger of vehicle in vehicular Natural 0151 hrs Yes 2 ✔ No Pendina accident 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) I-695 & SR-702, Essex, MD (Specify) roadway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ý

State 31. Date filed (Month Pay Year) 6 200 Registrar

Theodore M. King, Jr., MD.

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (I)em 23a)

Assistant Medical Examiner

32

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

29d. Date signed (Month, Day, Year)

November 24, 2007

7-09000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

na O'Brien		State of Maryland / Department of Hea For State Certificate of Dea		/giene Reg. N	lo. 200	7 271.0
Physicia	n/ 1	egistrar Decedent's Name (First, Middle,Last)		2. Date of Death Month Day November 21	C 0 (3. Time of Death 1430 hrs
edical Examir		Anna E. O'Brien la. Facility Name (if not institution, give street and number) 4b. City,	Town, or Location of Death		4c. County of Death	
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MD 2 d 2 shoul dth and M m 27 is m aumatic	ř	Mr. Lawrence O'Brien/ Nephew 10 Sixth	Ave. Baltimo	ore, Md. 2	21225	
ore, ss 1 an of Heal		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (not crematory or other plants) 4 Donation 5 Other Specify:	lame of cemetery, ce) .eemer Cem. 11	Date 2 1-26-07	Baltimor	
Baltimo permit. Page Department o Important: injury or ott	Ī	21. Signature of Funeral Service Licensie 22. Name a	a: 19204			
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Records, P.O. Box 68760, The law requires that the death certificate be executed fract has been signed by the attending physician and page 2 should be detached for use as the burial - transit	/Mec	23b. Was decedent pregnant in the		nancy	23d. Date of delive Month	ry Day Year
Sox 6876(leath certificate e attending phys	sician/M	past 12 months? 4 Pregnant at time of death 5 Other (S				
O. Bo t the dea by the a	Phys	Part II. Other significant conditions contributing to death but not resulting in the under	ying cause given in Part I.			o the cause of death?
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Division of Vital Records, tal or Attending Physician: The law requir as after death. Director: After this certificate has been s lied in by the fineral director, page 2 should I	catio	1 A Natural 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, far	1 Yes 2 No	28f. Location (St	treet and Number or	Rural Route Number, City
Divisipital or / ours after ours after filled in I filled in I filled in I	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Sta		
Div To the Hospital or within 24 hours afte To the Funeral Dic	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a cone) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	it the time, date and place, a in my opinion, death occurre	and due to the cause d at the time, date a	e(s) and manner as si and place, and due to	tated. the cause(s)
P. 2 2 8 8	Be	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (November 22,	· · · · · · · · · · · · · · · · · · ·
		30. Name and address of person who completed cause of death (Item 23a)	U.O.IVI.L.			
0		Ling Li, MD Assistant Medical Examiner 111 Penn Street, E	Baltimore, MD 21201			
Regi	tate		2			
DHMH 17 Rev 1		NOV 2 5 2007 ORIGINAL				

DHMH 17 Rev 1/2001 OCME 2006

		For	State of Ma	ırylan	d / Depa	artment of H	lealth ar	nd Mental Hy	giene		
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ter de item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent B Armed Forces? 1 Yes 2 N				an, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	Blac	k, White,	
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b dear he att ed for	sicia	in the past 12 months? 1 ☐ Yes 2 🔼 No	4□Pregnant at 9□Unknown			Other (specify)			IMIC	onth	Day Year
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dS, F	þ	Fait II. Other significant conditions of	manualing to death be	it not rest	aning in the a	nderlying cadse giv	en in raici.		Yes 2□No	3∐ Prob	47.
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Aec le law has t	du du							— 24a. Was	psy	vvere auto prior to coi death?	psy findings available mpletion of cause of
		OF Man and referred to medical						1□ Yes	2 kd No	1 ☐ Yes	2No
	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2□	ER/Outpatier	oth 30 DOA Oth	Or.	f Death (Check only ing Home 5 2 Res		ar (Cassid	5.1
OF Phys er this eral dir	1: To	27. Manner of Death	28a. Date of Injur	у	28b. Time o				how injury occur	- ' '	<u>y)</u>
Vision or Vita Attending Physician: r death. ector: After this certified by the funeral director, p	tiol	1 ⊠Natural 5 □ Pending 2 □ Accident investigation	(Month, Day	r Year)	Injury		k? Yes 2∐No				
Division or I or Attending Physiater death. Director: After this in by the funeral di	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju	ry - At ho	ome, farm, str	eet, factory, office		28f. Location	Street and Numb wn, State)	er or Rura	al Route Number,
Div Ital or A Its after al Direction by	Certification:		3,								
Divisi To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	cal	(Check only 2 Medical Exan	ysician: To the best of iner: On the basis of	examina							
To the within 2 To the complet	Medical	one) 29b. Signature and title of certifier	and manner sta	ited.		29c. Licens	e number		29d. Date signe	d (Month.	Day, Year)
F ≥ F 8			-Ulan) u	uD	D46	ころろく		11/19/0	17	,
•		30. Name and address of person who	completed cause of de	eath (Item	1 23a) (Type.	Print) .			1111110		100
4		Christopher d	fl ()			utain K	a to	sadena	MO	all	182
Sta	ate	31. Date filed (Month, Day, Year)	7 September 1	r's Sio	ture	EL.					-

DHMH 17 Rev 1/2001

			State of Maryla 1- State Registrar	and / Depa		ealth and M	ental Hy	giene 0 7	37492
			Decedent's Name (First, Middle, Last)				2. Date of De.		3. Time of Death
	Physici		Bernadine Valeria Pravlik				Month /	24 2057	4:02 pM
Ī	/Medio Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	ocation of Death		4c. County of Death	
	ZAGIIII		Coastal Hospice at The Lak		Ja1: 55	ury		Wic	
	Funeral		5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	th 9. Birth	place (State or Foreign intry)
	Director		205–26–7730 1□M 2⊠F 73	Yrs.	100,000		11/13/		sylvania
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	ocation				10d, Inside City Limits
	aryla shov	2	102.01.0	elmar					1 ☐ Yes 2 No
	Ne M	ecto		:THINGT	10f. Zip Code			10g. Citizen of What Cou	intry?
	with t	급	10e. Street and Number 9536 Wedge Way		21875			-	
	18 23	Funeral Director	9536 Wedge Way 11. Marital Status 12. Was Deceden Ever in	1 U.S. 13.		panic Origin? (Spe	cify Yes or No	U.S.A. 14. Race - Ameri	ican Indian,
	ter dee	ä	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No		Was Decedent of His If Yes, specify Cuban		Rican, etc.)		
93	urs a	by	3 ☐ Widowed 4 ☐ Divorced		1 ☐ Yes 2 ☐ No	Specify:		Specify: Whi	.te
21215-0036	within 72 hours after deeth with the Maryland ane. than "natural", or Itams 23s or 28s-1 show its Mudical Examiner mast be routified at	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupat	tion tring most of worki	na	16b. Kind of Business/Ir	ndustry
21	thin 7	npie	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired)		-		
2	be filed within 72 hours after deeth with the Marylar Ital Hygiene. Id other than "natural", or Itams 23s or 28s-f show other than "natural", or Itams 23s or 28s-f show svent, The Medical Evantiser nast be notified at	Completed	12	Inter	ior Decora		(m)	Retail Sal	es
pu	be fil tal H d oth	Be	17. Father's Name (First, Middle, Last)					, Maiden Sumame)	
y a	should be filed within and Mental Hygiene. s marked other than umatic svant, tra M	2	John Franks			Catherin		1 C r er, City or Town, State, Zi	in Code l
Maryland	12 sho h and 7 le m reum		19a. Informant's Name/Relationship (Type, Print)						p code)
	s 1 and 2 should f Heelth and Men item 27 is marks other treumatic		Richard Pravlik, Sr Husband	o. Place of Dispo	Wedge Way		Mary Lo	20c. Location - City or T	own, State
Baltimore,	8°= 5		1 Bunal 2 Cremation 3 Removal from State	cemetery, cre	matory or other place	11,	/28		
븚	ertmen ortant: injury		*4 □ Donation 5 ☑ Other (Specify/Entombment H	olly Hi	11 Mem Gar	of Facility Project)/	Middle Rive ki Funeral H	r, Maryland
Ba	permit. Depertm Importar any injur		21. Signature of Furieral Service Licensee					Essex, Maryl	
		-	23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.						Approximate Interval Between
	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	IZATI sequence of):		RCINO			Onset and Death
68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and cage 2 should be detached for use as the burial-transit	dicai Examiner	Cause (Diseese or injury that initiated events resulting in death) Last	requence of):			_		
P.O. Box 6	s that the death certilicate ned by the attending phy, s detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pre 1 Live birth 2 Fegnant at time of 9 Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delik Month	very Day Year
	quires tha in signed I uld be det	ρ	Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause giver	n in Part I.	23e. Did t	obacco use contribute to Yes 2 1 No 3 Pro	the cause of death?
of Vital Records,	The law requir sate has been si page 2 should	Completed					24a. Was autor perfo	an 24b. Were aut prior to comped? death?	copsy findings available ompletion of cause of
ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?			26. Place of Death	(Check only o	one)	
>	ys dir	To	1 Yes No Hospital: Inpatient 2	ER/Outpatie	nt 3□ DOA Othei	4 Nursing Ho	me 5 Resi	dence 6 Other (Spec	ify)
0	ng Ph Iter th ineral		27. Manner of Death 28a. Date of Injury (Month, Day Year	28b. Time o	Work'	?	28d. Describe	how injury occurred	
Sio	andiv eath. or: A	catio	/2 Accident investigation			es 2 No			
Division	il or Attanding P after death. Director: After t d in by the funera	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - A building, etc. (Special Coulding Special Couldi	t home, farm, st. ecify)	reet, factory, office		28f. Location (City or To	Street and Number or Rui wn, State)	rai Houte Number,
	pite ours ille	Medical Ce	29a. Certifier (Check only one) (Check only one) (Check only one)	knowledge, deal	th occurred at the time	e, date and place, inion, death occurr	and due to the ed at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fun completely	Mec	29b. Signature and title of certifier		29c. License	number		29d. Date signed (Month	, Day, Year)
	F \$ F 8 /			MA	1 00	05741	'e	11-24	-0 7
7	16		30, Name and address of person who completed cause of death (I	tem 23a) /Tuna	Print)	0 11		(/	0.19.00
	12		WA 6-Hu	WAN WA	RIS CONST	AL HOSP	ICR F	11-24 20 BOX 1733	1 Al Gibreno wil
	Sta	te	31 Date filed (Month, Day, Year) 32 Registrar's Si	gnature	200	., .,,,,,,,			
	Registr		NOV % 6 2001 12 8000	12 19					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Reg. No. 2007 37493 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 23,2007 8815 AM November /Medical Jadaben Gordhanbhai Pate1 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Prince George's Doctors Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Yea.1912 Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 ☐ XF Director 95 April 20, -214-13-1515 India Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Tyres 2 □ No Maryland | Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13903 Pleasant View Drive Funeral 20720 India 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Máryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ģ 3 Wildowed 4 □ Divorced Asian-Indian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 House wife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Dwarkada Kalyandas Laduben Chunilal Pate1 injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 Is any injury or other tra Bhagu Patel/son 13903 Pleasant View Drive Bowie, Maryland 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 11/24/2007 Odenton, Maryland 21. Sign ore of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. Thomas uanta R 1411 Annapolis Road Odenton, Maryland 21113 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ocar /Medical Due to (or * a consequence of): Examiner ormar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be exect Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate I performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural in 24 hours... or the Funeral Director... 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

Box 68760

Records, P.O.

Division or Vital

State Registrar

29b. Signature and title of certifie

2

egistrar's Signature

GoodLuck Roan

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Plackouich orman /Medical 2007 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis timore ommons Social Security Number **Funeral** Age (In yrs. last birthday Year)1915 217-20-5520 Days Hours 92 Director Yrs. Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County la or 28a-f show t be notified at 28a-f show 10c. City, Town or Location 10d. Inside City Limits Directo Maryland N/A Baltimore 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 338 S. Mount Street items 23a 21223 must ! Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or iten the Medical Examiner 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 \$ 1 ☐ Yes 2 No White 3 X Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) d 2 should be filed w th and Mental Hygier 7 is marked other the Chef Restaurant traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rado Plackovich 2 Hellena 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar ant: If Item 27 is Kimberly D. Mitchell (Grandaughter) 489 N. Patuxent Rd., Odenton, MD. 21113 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State important: If it any injury or c 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 11/23/07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical the SS use IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 4☐Pregnant at time of death Day the ☐Yes 2☐No 5 ☐ Other (specify) Year 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? should be 1 ☐ Yes 2[H0 3 Probably 4 □Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) P 1 Yes 2 No Other: 1 Inpatient this 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral Certification: 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Director: After 28b. Time of 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Funerai 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 P Check one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) S s of person

Registrar DHMH 17 Rev 1/2001

State

31. Date filed

(Month, Day)

Year)

6

32 Registrar Signature

Avenue

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death PUMPHREY **Physician** Month DONNA 3EPM 20 /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HARBOR HOSPITAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 26,1952 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 262-23-5082 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Show 1 Yes 2 No Director Maryland N/A Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be n 3727 St. Margaret Street 21225 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry of Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph D. Breighner Catherine Evans ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas F. Pumphrey (Husband) 3727 St. Margaret Street, Baltimore, Maryland 21225 20a. Method of Disposition
1 Burial 2 InCremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 3 ☐Removal from State Bayview Crematory 11-21-07 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License McCully-Polyniak Funeral Home P.A. 21225 237 E. Patapsco Avenue, Baltimore, Maryland Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final MONARY Physician disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine DIABETE that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760, attending physician I for use as the buria ARTERY DISEASE OROMARY Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed by to d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy this certificate 1∏ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes V No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

STREET Registrar's Signature

MD

29c. License number

0052205

29d. Date signed (Month, Day, Year)

, SUITE 203, BALTIMORE MD-21225

				Amend Items 2,23a,26 per dr., g873,11/26/07dhb.	a Mental Hy	Reg. No.	6
		Physic	ian	1. Decedent's Name (First, Middle, Last) Edward J. Powichroski	Month	eath 11/18/2007 3. Time of Dec	ath SPN
	0.00	/Medi Exami			or Location of Dea	1 1001	1
		Exami	ici	College Manor Luthe		. Baltimore Cour	nty
		Funeral Director		213-12-9531 (MAN) 2LP 07 Yrs.	Hrs. 8. Date of Bi Min. (Month, D Feb. 2	orth (2) Pear) 9. Birthplace (State or For Country) 7,1920 Maryland	reign
		land bw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City L	imits
		Many a-f she	ţŏ	MD Baltimore Baltimore		1 ☐ Yes 2 €	Š No
		th with the 23a or 28 ast by right	al Director	10e. Street end Number 10f. Zip Code 21228		10g. Citizen of Whet Country? USA	
	020	: 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mentel Hygiene. Ism 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exarting must be rediffed at	by Funeral	11. Marital Status 12. Was Decedent Ever in U,S.	? (Specify Yes or N uerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc. Specify: White	
	5-0	72 hor	eted	15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working	16b. Kind of Business/Industry	
	121	within ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		US Government	
	d 2	filed v Hygie Sther t	Be Co	1201	Name (First, Middle	e, Maiden Surname)	
	ylan	Wild be Wentel Irked o	To B	Alexander Powichroski Aga	tha Bar	on	
	Man	12 sho h and I is me	ľ	19a. Informant's Name/Relationship (Type, Print) Michael Powichroski /son 19b. Mailing Address (Street and Number of 3800 Ednor Road)	<i>r Rural Route Numl</i> Baltim	per, City or Town, Stete, Zip Code) ore MD 21228	
	Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any Injury or other traumatic once.		20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) **D Burial 2 □ Cremation 3 □ Removal from State Holy Rosary Cemetery	Date	20c. Location - City or Town, State	
	Baltin	permit. Pa Departmen Important any Injury		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	300 Mac	e Ave. Balto. MD	
				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cer shock, or heart failure. List only one cause on each line.		of Essex 21221	
•		Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death) Hypertensive Cardiomyopathy e. Due to (or as a consequence of)		intervel Betwee Onset and Deal years	n ih
S	68760,	ficete be executed g physician and as the bunal-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):			
8	Box 68	leath certifice attending ph		d.			
W.	. B	death he atte	Physician/M	Part II. Other alignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I.	23b. Did	I tobacco use contribute to the cause of d	eath?
~	9.	het the ad by t detech	Phy	dementia	1	Yes 2 No 3 Probably 4 Uni	(nown
#X	Division of Vital Records,	The law requires thet the death certiste has been signed by the attending page 2 should be deteched for use a	Completed by	uclusion bady myasitis.		s an autopsy ormed? 24b. Were autopsy findi available prior to completion of caus	_
	Rec	sician: The law certificate hes t lirector, page 2 s	gmc		1	of death? Yes 2☑No 1☐Yes 2☐No	
	ta		BeC	25. Was case referred to medical 26. Place of	Death (Check only	one)	
	of V	Physician: this certifice ral director, p	၉		g Home 5□ Res		g
	ion	De Te	Certification:	27. Manner of Death 1 Natural 5 Pending investigation investigation 28a. Date of Injury 28b. Time of Injury Work? 1 Natural 5 Pending investigation investigation investigation investigation	28d. Describe	how injury occurred	
	Divis	c	Certific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or Rural Route Number, wn, State)	
(1)		To the Hospital or Att within 24 hours efter of To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place in the best of my knowledge, death occurred at the time, date and place in the best of my knowledge, death occurred at the time, date and place in the best of my knowledge, death occurred at the time, date and place in the best of my knowledge, death occurred at the time, date and place in the best of my knowledge, death occurred at the time, date and place in the best of my knowledge, death occurred at the time, date and place in the best of my knowledge, death occurred at the time, date and place in the best of my knowledge, death occurred at the time, date and place in the best of my knowledge, death occurred at the time, date and place in the best of my knowledge, death occurred at the time, date and place in the best of my knowledge, death occurred at the time, date and place in the best of my knowledge, death occurred at the time, date and place in the best of my knowledge, death occurred at the time, date and place in the best of my knowledge, death occurred at the time, date and place in the best of my knowledge, death occurred at the time, date and place in the best of my knowledge, death occurred at the time, date and place in the best of my knowledge, death occurred at the time, date and place in the best of my knowledge.	ace, and due to the occurred at the time	cause(s) and menner as steted. , date and place, and due to the cause(s)	
		Vithii To the comp	×	29b. Signature and titlé of certifier 29c. License number		29d. Date signed (Month, Day, Year)	
*				Jasenbleg Mis D24121		11/19/07	
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRUCE ROSENBEACT 21 WEST RD	DWSON/	MD 21204	
14		Sta	te	31. Date filed (Month, Day-Year) 32. Registrar's Signature 2007	,,,,,,,		
		Registr		NUV 2 6 2001 Johnson St. Sparker			

ercell Phillips	State of Maryland / Department of Health and Mental Hygiene 1-For State amend #9,11,12,15, Certificate of Death 2/04/08 JH Reg No. 2007 374	q
Physician/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	Ĭ
Medical Examine	Percell Phillips October 31, 2007 1108 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	_
	Johns Hopkins Bayview Medical Center Baltimore	
Funeral	5. Social Security Number unk 5. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or	
Director	1 X M 2 F 52 Yrs. Months Days Hours Min. Dec 17, 1954 Foreign Country) MD	•
'n	Usual Residence of Decedent	
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the Maryland or 28a-f show any ified at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	\dashv
uit the Maryland 23a or 28a-f sho notified at once al Director	5009 Frankford Avenue 21206 USA	
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once leted by Funeral Director		\dashv
or items 23	Never Married 2XX Married Armed Forces? Unit If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.	
ural".	3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes, 2 X No specify: Specify: Specify: black	\dashv
72 hours af "natural" al Examin	Elementary/Secondary (0-12) College (1-4 or 5+)	-
	unk 12 unk 0 Carpenter City Govt	
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21215-0036 ould be filed within 7 l Mental Hygiene. s marked other than it event, the Medita To Be Comple	Harold Phillips Minnie Sheridan 19a. Informant's Name/Relationship (Type Brint) 19a. Informant's Name/Relationship (Type Brint) 19b. Mailtog Address (Street and Number of Rutal Route Number, City or Town, State, Zip Code) 3/48 Old York RD. #2 Balto, Md. 21218	\dashv
MD and 2 sho alth and m 27 is aumati	19a. Informents Name/Relationship Type Frint) ShirCola M. Philips/spouse 0.C.M.E. 19b. Maiing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3/48 Old York RD. #Z Balto, Md. 21218 111 Penn Street Baltimore, MD 2120-1	[
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 Removal from State crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
Baltimore, semit. Pages I an Department of Her Important: If ite njury or other tr	4 Donation 5 X Other Specify: in State	
Balti permit. Departm Imports injury o	21. Si. ture of Fur al Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street	
Physician	Baltimore, MD 21201 23a. Fart I. Enter the hisease, and of mplicity in sithat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval	
'Medical	falure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic intoxication (morphine) Death	d
aminer	or condition resulting in death) Due to (or as a consequence of):	ヿ
9	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	ᅱ
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60, e be executed ysician and burial - transit	X UNPENDED #MSNDEDII,27,28a-f, perME,g873, 11/2707 TT	
3760 ficate b g physic s the bu	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day Year	\neg
Box 6876(c) death certificate the attending phy ed for use as the br nysician/Me	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year	
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ds, equire een sig	liver disease 24a. Was an autopsy findings availab prior to completion of cause of	
Division of Vital Records, talor Attending Physician: The law require rs after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed	autopsy prior to completion of cause of death?	
Vital Rec ysician: The I his certificate I director, page	25. Was case referred to medical 26.Place of Death (Check only one)	-
Vita hysicia this ce I direct	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 PER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other	
1 of V ding Ph. After tl funeral	27. Manner of Death 28a. Date of Injury (Month, Day, Year) Natural 5 Pendias 28a. Date of Injury (Month, Day, Year)	
Sior Attend r death ector: by the	Natural 5 Pending Investigation Fnd 10/31/2007 Fnd 10:20 am 1 Yes 2 X No unk 2 Accident 28. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Cit	tv
Division o spital or Attending hours after death. Internal Director: After y filled in by the fune Certification:	Suicide 4 Homicide 4 X Could not be determined (Specify) residence (Specify) residence 5009 Frankford Ave. Baltimore, MD	"
	23a. Certified and 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
To the Ho within 24 To the Fu completel	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 1, 2007	
	- Min Drashell, ME	
	30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State	NT 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	\dashv
Registra	NOV 2 6 2007 Degree of Special	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician November 3:58 A. M IRMA SKINNER REICHENBACH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TOWSON
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Baltimore Gilchrist 8. Date of Birth (Month, Day, Year) June 7, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🔯 F 75 1932 218-28-6430 Marvland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 🙀 No Director Maryland Harford Forest Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 101 Woodlawn Avenue U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry th and Mental Hygiene.
7 Is marked other than "natui traumatic event, the Medical. 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 2 years Nurse Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Skinner Helen Forster ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 Is
any Injury or other trau 20011 Carl D. Glaeser (son) 1620 Wisconsin Avenue NW Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Highview Memorial Grdns. 11-24-07 Fallston, Maryland ²² Name and Address of Facility Mitchell—Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland Signature of Funeral/Service Licenses 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner PAN. burial-transit that initiated events resulting in death) Last requires that the death certificate be exec Due to (or as a consequence of): physician a Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Dav Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the inector, page 2 s autopsy performed2 Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 🗌 Inpatient မှ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 20, 2007 uno m 30. Name and address of person who completed cause of death (Kem 23a) (Type, Print) Charles Sr Balto, Md 2, 20 % BMC 6701 (gistrar's Signature 31. Date filed (Month, Day, Year) NOV 2 6 State 2007 Registrar

			1 - For State Registrar	State of Ma	aryiand	-	artment of F rtificate of	lealth and M <i>Death</i>		gien Reg. N		07!00		
7	Physici	an	1. Decedent's Name (First, Middle, Last						2. Date of De	eath	2001	3. Time of Death		
4.0	/Medi	cal	Ralph Donal 4a. Facility Name (If not institution, give				4h City Town o	r Location of Death	Month NOV.	22	2007	12:15pm м		
K	LAGIIII	ICI	Gilchrist Hospice				Tow					.timore		
	Funeral Director		5. Social Security Number 6. Security Number 003-05-1282	X 7. Age	e (In yrs. Ia 88	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da June	th ay Year .6,	9. Birti Co	hplace (State or Foreign unity) Mass •		
	yland Iow at		10a. State 10b. County 10c. City, Town or Location 10d.											
	e Marr Sa-f sh tified	ctor	MD Howard	i	Ma	arrott	sville					1 ☐Yes 2 📉 No		
	th with th 23a or 28 ust be no	ral Director	10e. Street and Number 11686 Route 99				10f. Zip Code 211	04		10g. Ci	g. Citizen of What Country? USA			
21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 M Yes 2 □ N If Yes, Give Year or Dates: R	0 106	50	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2∏ No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.))-	14. Race - Amer Black, White Specify: Wh	e, etc.		
15-(n 72 h "natu edical	letec	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Deced	lent's Usual Occup	ation during most of work d)	ing	16b. H	Kind of Business/I	Industry		
212	withiu giene. r than the Ma	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		Medical			U	S NAVY			
	be filed tal Hygi d other event, tl	Be C	17. Father's Name (First, Middle, Last)				1	18. Mother's Name			,			
Maryland	should be ind Mental marked o	2	Harold Rich 19a. Informant's Name/Relationship (Ty	ma (Print)		405 14-77			Ethel					
	and 2 sl ealth an n 27 is r ier traur		Mrs. Sandra Hawkin		er)			and Number or Rura Marriott				(ip Code)		
Baltimore,	les 1 a of Height fitem		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ R	tomoval from State	20b. Pla		sition (Name of natory or other place		Date		ocation - City or	Town, State		
Ē	t. Pages rtment of I rtant: If its njury or o	11	4 □ Donation 5 □ Other (Specify)			Count	y Cremat:	ion 11/2			kesville			
Ва	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events.		21. Signature of Funeral Service License Sugar C H	night M	10076	64 Å	AIGHT FUI ykesville	NERAL HOM e, MD 2178	E & CHA 84 (41	PEL 0)-	, P.A. (795-1400	Box 195)		
	-		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final						or respiratory a	rrest,		Approximate Interval Between Onset and Death		
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	sit (niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	conseque	ence of):								
–	execul n and	Examiner	that initiated events resulting in death) Last	Due to (or as a	conseque	nce of):								
08/PN	eath certificate be executed attending physician and for use as the burial-transit	edical		i										
	certifica ding ph		IF FEMALE:	On If you sylenman										
.C. Box	requires that the death cer een signed by the attendir nould be detached for use	Physician/IV	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal d	leath 3□	Ectopic pregnancy Other (specify)				23d. Date of deli Month	very Day Year		
ras, r	w requires that the d been signed by the should be detached	Completed by Pi	Part II. Other significant conditions con		- 4	ing in the un			23e. Did t			the cause of death?		
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	: The licate hat; page	Com								rmed?	- death?	ompletion of cause of 2 □ No		
VII	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatien	+ 2□=	R/Outpatient	Othe	26. Place of Death				11.		
101	ng Phys ter this neral dir	-	27. Manner of Death	28a. Date of Injury (Month, Day	, 2	8b. Time of Injury	28c. Injury Work	4 Li Nursing Hor	ne 5 ∐ Resid 28d. Describe l		6 Other (Spec	ity) 1-tospice		
UNISION	tendir leath. tor: Al the fu	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be				M 11	Yes 2 □ No						
2	al or Al	Certification:	4 Homicide determined	28e. Place of injur building, etc.	y - At hom (Specify)	e, farm, stre	et, factory, office	2	28f. Location (5 City or Tov	Street ar vn, State	nd Number or Rui e)	ral Route Number,		
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	To the within	M	29b. Signature and title of certifier	1 87)	0	29c. License	_			te signed (Month			
•		-	30. Name and address of person who co	mpleted cause of dea	attb (item 2	3a) (Type F	Print)	5205				22,2007		
	6		W.A. Rilay (5 Bonc	670	1 N.	Charles	St. Ba	lt. 1	nd	2020	>		
	Sta Registr	te ar	30. Name and address of person who co Wh. L. (49 31. Date filed (Month, Day, Year) NOV 2 6 2007	32. Registrar	's Signatur	Good	V				·			
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			Decedent's Name (First, Middle, Last)						2. Date of De.		3. Time of Death
	Physici /Medic	_	Heleu Rizz	0					\ \	25 200	- M
	Examin		4a. Facility Name (If not institution, give s	street and number)			4b. City, Town, or	Location of Dea	th	4c. County of De	ath
			Ridgeway Manor Nur	sing Home	(In use last h	irthday)	Caton:	sville If Under 24 Hrs	8. Date of Birt	Baltin	IOTE
*	Funeral Director		5. Social Security Number 6. Sex 1	M 2⊠F	(In yrs. last bi	Yrs.	Months Days	Hours Min	(Month Da		irthplace (State or Foreign Country) rvland
			Usual Residence of Decedent						102	TIC	
	anylan show	_	10a. State 10b. County		10c. City, Tov	vn or Loc	ation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	he M	ecto	Maryland		Balti	more	10f. Zip Code		1	10g. Citizen of What (
	with Se or	급									
	death ms 23	Funeral Director	432 Westgate Road	12. Was Decedent B	ver in U.S.	13. W	Vas Decedent of Hi Yes, specify Cuba		Specify Yes or No	USA 14. Race - Ar	nerican Indian,
9	or fte	Fur	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 ☑N If Yes, Give	0	l l	Yes, specify Cuba		no nican, etc.)		Me, etc. Vhite
003	72 hours after death with the Maryland naturel', or items 23s or 28e-f show dreal Examinational be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	100						
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212	filed within Hygiene. Ither then "	omo	Elementary/Secondary (0-12)	College (1-4or 5- 2		ecut	ive Assis	stant		Banking	
b	be filed stal Hygi od other event, I	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle,	, Maiden Sumame)	
ylaı	should be and Mental le marked c	70	Matthew Lukosevici	110-110				Agnes			
Maryland 21215-0036	12 sh n and 7 le m reum		19a. Informant's Name/Relationship (Ty				1000			er, City or Town, State	
	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 le marked other then "naturel", or frems 23s or 28e-1 show or other treumatic event, the Medical Examinations in the notified at		Louis Rizzo 20a. Method of Disposition	Husba	20b. Place	of Dispos	sition (Name of		ltimore. Date	Maryland 20c. Location - City	21229 or Town, State
JO I	Pages nent of I int: If its iry or o		1 🛱 Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)		cemete	ery, crem	iatory or otner piac		28/2007	Baltimore	Maruland
Baltimore,	7 5 5 5		21. Signature of Funeral Service License			22	Name and Address	s of Facility St	erling A	shton Schw	ah Witzke
ä	Depar Impor eny ir		Handa L	Lemmer)	Fui 1	neral Hom 630 Edmor	ne of Ca ndson Av	tonsvill enue; C	e, Inc. atonsville	, MD 21228
*			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused ne cause on each lin	the death. Do	not ente	er the mode of dying	g, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
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o,	be executed sictan and burial-transit		resulting in death) Last	Due to (or as a	consequence	of):					
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ox 68	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE:	23c. If yes, outcome of	of pregnancy					23d. Date of o	delivery
Bo	atten atten	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal deat		Ectopic pregnancy Other (specify)			Month	Day Year
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S,	es that igned t be det	by P	Part II. Other significant conditions con	ntributing to death bu	it not resulting	in the un	derlying cause give	en in Part I.			to the cause of death?
ecords,	w require been si should b	ted	Chonie renal	failure					1 🗆 '	Yes 2 No 3	Probably 4 (1Usknown
ec	e lawr has be je 2 sh	Completed	Hypertension						24a. Was auto	psy prior to death	autopsy findings available o completion of cause of
al B			Hypoterore				<u></u>		1 ☐ Yes	2 → NO 1 □ Y	
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	ADER/O		Oth		eath (Check only o	idence 6 Other (S	20061
of		1: To	1 ☐ Yes 2 ☑ No	28a. Date of Injur	nt 2□ER/0 y 28b.	Time of	28c. Injun	v at		how injury occurred	овспу)
ion	uttending I death. ctor: Alter y the funer	atloi	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	rear)	Injury	M 1 🗆	Yes 2 □ No			
Division	l or Attendater deatl Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, i	farm, stre	eet, factory, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
	urs aff								<u> </u>		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attencompletely filled in by the fune	Medical			examination a					cause(s) and manner date and place, and o	
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)
	->=0		Hivesore Rees	cosus			DIS	1667		11-25-11	2007
1	Y		30. Name and address et person who co	ompleted cause of de	eath (Item 23a)	(Type, I	Print)	2 + CDG	01 0	The	and 21061
6			The district School	CIZOLD 7	310 (C)	TCECA	e myune	7.308	Olen As	in ofamil	(00)
ŀ	Sta Regist		31. Date filed (Month, Day, Year) NOV 2 6 2007	32. Registra	a s signature	1000	The said				